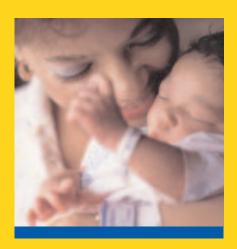
THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010

Annual Implementation Plan

Year 2002











Government of the District of Columbia Anthony A. Williams, Mayor



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Annual Implementation Plan

Year 2002



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ACKNOWLEDGEMENTS

Carolyn N. Graham Deputy Mayor for Children, Youth, Families and Elders

James A. Buford Acting Director Department of Health

Michael Richardson, MD Interim Director for Medical Affairs

Herbert Weldon Senior Deputy Director Medical Assistance Administration Ronald E. Lewis Senior Deputy Director for Health Promotion

Theodore Gordon Senior Deputy Director for Public Health Assurance

William Steward
Acting Senior Deputy Director
Substance Abuse Administration

State Center for Health Statistics Administration

Carl W. Wilson, Director, SCHSA

2010 Work Group

Patricia Theiss, Coordinator Joy Phillips, PhD Fern Johnson Clarke, PhD John Sumner, PhD Manzur Ejaz, PhD Willis Bradwell

2010 Focus Area Program Liaisons

Sherry Billings Leona Brown John Davies-Cole, PhD Cheryl Eason Gabriella Gonzales, MD Marcia Harrison Paulette Jackson Vincent Kofie Deneen Long-White Rosie McLaren Elizabeth Neilson LaRah Payne, ScD Amelia Peterson Dozier Juanita Reaves, PhD Heather Reffett Michael Richardson, MD William Robertson Luau Temprosa Kimberly Turner

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^{*} Section will be submitted in the AIP for 2003

Introduction

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The Annual Implementation Plan (AIP) is a companion document to the District of Columbia Healthy People 2010 Plan. Goals, objectives and recommended strategies in the Healthy People 2010 Plan are focused on eliminating health disparities and extending the years of healthy life for all residents of the District of Columbia by the Year 2010.

The AIP is a one-year community action plan which contains priority 2010 objectives selected from the Healthy People 2010 Plan, along with strategies that are to be measured for progress achieved within a one-year period. If significant achievements are made in the given period, the AIP objectives will progressively lead to the accomplishment of the long-range goals in the Healthy People 2010 Plan. Progress towards achievement of these objectives will be measured at the end of the implementation year (December, 2002).

Implementation of the AIP is the responsibility of each Focus Area Program and its Program Advisory Committee in collaboration with local health care consumers and providers in both the public and private sectors. It is the practice of the Department of Health (DOH) agencies to work through cooperative agreements with other government agencies. This practice is reflected in the joint development of various components of the AIP. Implementation activities will also be fostered through written agreements which the agencies represented on the Phase I Healthy People 2010 Planning and Development Committee have made with other state health advisory councils or agencies.

MANDATE

The mandate for developing and implementing the Healthy People 2010 Plan at the local level was derived from the federal Healthy People 2010 mandate coordinated by the US Department of Health and Human Services. The purpose of this national effort is to improve the health of all Americans by the year 2010. The Healthy People 2010 Plan was developed in an effort to address lessons learned from the Healthy People 2000 Plan. Designed to be more user friendly and inclusive, the Healthy People 2010 Plan has measurable objectives that are grounded in baseline data; progress is measured in relation to the baseline. In an effort to eliminate health disparities, the federal plan sets the same 2010 target for all five of the standard racial and ethnic population groups. In the District, data gathering and analysis to establish baselines for each racial and ethnic population group are underway at the DOH/State Center for Health Statistics.

PHASES IN THE EVOLUTION OF THE PLAN

The development and implementation stages in the evolution of the 2010 Plan have been designated as Phase I and Phase II activities, respectively. The Phase I Healthy People 2010 Planning and Development Committee was formed by the SCHSA's team of health statisticians and a public health advisor to work with liaisons from each of the program focus areas to design, develop, produce, and implement the 2010 Plan in the District. This was done in collaboration with community-based organizations and community advocates. The publishing of the 2010 Plan and its Executive Summary signaled the conclusion of the Phase I activities.

In Phase II, the implementation and evaluation phase of activities, the Healthy People 2010 Planning and Development Committee has become the Planning, Implementation and Evaluation Committee, known as the 2010 Work Group. The 2010 Work Group will develop an Annual Implementation Plan (AIP) with strategies that will contribute to the achievement of the goals and objectives in the Healthy People 2010 Plan. In establishing the AIP, the 2010 Work Group must give priority to those objectives which will have a significant impact on the health of residents, while maximizing the use of limited resources. The recommended actions and their implementation are designed to address the special needs of the District of Columbia.

AIP PRIORITIES

Of the twenty-one Focus Areas in the District of Columbia Healthy People 2010 Plan, the below-listed twenty have been selected for inclusion in the first AIP (January to December of 2002). Pediatric Dental Health will be included in the next AIP (January to December of 2003).

Asthma Injury/ Violence Prevention

Cancer Maternal, Infant and Child Health
Cardiovascular Disease and Stroke Mental Health and Mental Disorders

Diabetes Nutrition
Disabilities Primary Care

Emergency Medical Care Public Health Infrastructure Environmental Health Sexually Transmitted Diseases

Health Care Finance Substance Abuse

HIV/AIDS Tobacco
Immunization Tuberculosis

Developing the AIP, at the Focus Area Program level requires considerable involvement of program staff with Advisory Group members. And the assistance of community-based

organizations and community advocates is essential to the successful implementation of the AIP.

In order to determine the Healthy People 2010 program objectives to be included in the AIP, a priority selection process was utilized. During the process, the following issues were given consideration:

- Focus Areas addressing the leading causes of death in the District of Columbia.
- Strategies that would produce the greatest amount of impact with available resources.
- Consistency with the new federal direction of focusing AIPs on a few achievable areas rather than on numerous areas.
- Potential cutbacks in federal health funding;
- · Areas of program staff expertise.
- Consistency with other related Healthy People 2010 projects.
- Availability of staff person-days and resources to successfully carry out actions.

Following this process, twenty of the twenty-one Healthy People 2010 Focus Areas were selected for inclusion in the first AIP. For each focus area, one to three objectives were chosen for implementation from January to December of 2002.

Attention has been given by the health statisticians in the 2010 Work Group to the uniformity of format and standards for the Focus Area Program sections in the AIP, in addition to the reliability of the baseline data.

The preliminary draft of the AIP was released in December of 2001 for public review prior to the Public Hearing in January of 2002. Since April, the final version of the AIP has been accessible by Internet at the DOH website of www.dchealth.dc.gov. The printed document should be available for distribution by July of 2002.

FORMAT AND ORGANIZATION

The AIP is derived from goals and objectives presented in the District of Columbia Healthy People 2010 Plan. The objectives stated in this AIP are worded similarly to those stated in the first edition of the District's Healthy People 2010 Plan. Recommended actions have been chosen to address current issues in relation to available resources in the implementation year.

The goals and objectives in the twenty focus areas in this document are grouped according to the four federal Healthy People 2010 Plan Objective Subject Areas:

- Promote Healthy Behaviors
- Promote Healthy and Safe Communities
- Improve Access to Quality Health Care Services
- Prevent and Reduce Diseases and Disorders

The 2010 Objectives were designed for achievement by the year 2010, and were foreseen when written as accomplishable within ten years. For ease of progress evaluation, the 2010 Objectives are stated as measurable ones grounded in baseline data. In this AIP, only the actions (strategies) within a given year in the implementation phase are measured. In addition to the goals and objectives, this document contains: recommended actions, the rationale for these actions, strategy statements and resource requirements. The recommended actions specify the tasks related to obtaining of the target. The rationale statements justify the selected strategy. The resource requirement paragraph lists those resources necessary to accomplish the recommended actions.

In order to clearly identify the goals, objectives, and recommended actions in the AIP, a coding system has been developed. Each objective is identified by two components, the first of which is the number of the Focus Area and the second is the numerical sequence of the 2010 Objective within the Focus Area. For example, *Objective 2-1 is from the Focus Area on Tobacco Use (Number 2 in the Table of Contents and in the Chapter on Promote Healthy Behaviors) and is the first AIP objective listed under Tobacco Use. Objective 2-1 is as follows: Reduce to 18.5 percent the proportion of adults (18 years or older) who are current smokers. Baseline: 20.9 percent of adults were current smokers in the District of Columbia in 2000,according to the Behavioral Risk Factor Surveillance Survey.*

MONITORING AND EVALUATION

Realizing that the actions taken over a one-year period represent only a fraction of the effort required to achieve the 2010 goal, the 2010 Work Group believes that actions taken toward implementation can have a measurable influence on the reduction of problems associated with achieving the 2010 objectives. The actions taken toward the goals and objectives in the twenty focus areas in this document are grouped according to the four federal Healthy People 2010 Plan Objective Subject Areas listed on page 6.

The actions taken toward implementing the AIP will be closely monitored and evaluated internally by the 2010 Work Group, in addition to a proposed team of outside evaluators as yet unidentified. A specific format for monitoring AIP implementation will be developed. It is foreseen that bi-monthly reports on the progress of implementation of recommended actions will be developed for internal monitoring and evaluation purposes and public information. The reports will serve as the basis for year-end impact evaluation on each of the focus area programs in the four sections in the AIP.

LEADING HEALTH INDICATORS

Ten leading health indicators have been selected by an interagency work group within the federal Department of Health and Human Services and validated in a process of regional and national meetings.

The indicators were selected based on their ability to motivate action, the availability of data to measure their progress and their relevance to broad public health issues. These indicators are the following:

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- · Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- · Immunization, and
- · Access to health care.

Special attention will be given to these ten areas whenever they appear among the 2010 objectives in this AIP.

MEASURING HEALTH DISPARITIES

There is a critical need in the District of Columbia for the development and institution of baseline health status measures and intervention strategies to address the disparities in minority health status. Factors contributing to the urgency of the need are the following:

- The District has a large and growing body of residents composed of racial and ethnic minority population groups.
 - Minorities, including Blacks or African Americans, Hispanics or Latinos, Asian/Pacific Islanders, and American Indian/Alaska Native, and other minorities comprise approximately 72% of the District's population. The number of Hispanics in the District of Columbia continues to increase annually. This group increased from 5.2% in 1990 to 7.9% in 2000. The racial diversity of the District's population offers a base for analysis of health conditions, as well as risk and protective factors among subgroups of minorities that allows for definitive studies.
- Residents in the District experience a large number of excess deaths.
 - In 1999, the five leading causes of death among residents were heart disease (24.7%), cancer (22.4%), cerebrovascular diseases (4.8%), HIV/AIDS (4.2%), and hypertension (3.7%). Improper diet and lack of exercise, substance abuse, unhealthy sexual behavior and violence are

major contributors to these conditions. Consequently, these diseases can be mitigated through behavior change. Research studies are needed to focus on the development of effective intervention strategies to effect behavioral change.

• Research into conditions disproportionately affecting minority health is needed.

The District of Columbia is in the process of establishing a system of integrated health databases that will be available to researchers for the study of conditions that disproportionately affect the health of minorities in the District.

Ready access to a database of vital records data, disease registries and other pertinent data in a user friendly system is necessary to conduct research that is crucial to understanding the underlying causes of the persistence of poor health status among Black residents. Such a database will be a major step in filling the data gaps in minority health within the District of Columbia.

An integrated health information system in the District will facilitate the linkage of various health and related databases throughout the health care delivery system and make available more complete information on the prevalence and etiology of disease conditions among minorities and other District populations. Data linkage and standardization of subscribing databases will also provide more comprehensive indicators of socioeconomic, environmental and chemical factors that may account for the disparities in health that so obviously exist in the District and other similar jurisdictions.

More culturally sensitive research is needed.

More culturally sensitive research, including the design of culturally appropriate data intake forms, can be encouraged through greater involvement and training of minority health researchers and health professionals.

Greater involvement of minority health researchers as principal investigators and as members of study teams, particularly representatives from the population groups to be studied, will facilitate the development of culturally sensitive study designs and data collection instruments. A program for the training of minority health researchers at the DOH/SCHS will motivate minority researchers and health professionals.

 Coordination of research efforts is needed to maximize the impact of research studies and findings.

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Interagency partnerships in minority health research can provide insight into a broad spectrum of factors impacting minority health status of residents. The sharing of research findings will permit effective targeting of research efforts. Targeting research studies to focus on various aspects of a specific problem can lead to the resolution of particular health problems. Research results will be essential to health departments in responding to the health care needs of minority groups.

There is a scarcity of issue-oriented data to serve as a basis for policy decisions.

Sound data are needed to support policy direction, to establish legislative agendas and to enlist the support of community-based organizations and media to serve as advocates for minority health issues. A minority health information system at the SCHSA soon will be able to provide information on pertinent topics and issues and serve as a resource for references, studies and publications on minority health topics.

EFFECTIVE STRATEGIES FOR ELIMINATING DISPARITIES AMONG DISTRICT RESIDENTS CAN HAVE BROAD APPLICATIONS

 Strategies that effectively reduce health disparities in the District of Columbia can have national implications.

The District of Columbia is strategically located for influencing health policy decisions at the federal, state, regional and local levels.

The District's being the nation's capital and the seat of the federal government offers a unique opportunity to influence policy decisions that have national consequences.

Issues arising from quality data analyses can serve as the basis for national forums and position papers that can be used to attract attention and generate the interest of federal, state, and local legislators.

PROMOTE HEALTHY BEHAVIORS

- 1. Nutrition
- 2. Tobacco Use

Nutrition

Focus Area: Nutrition

1) **2010 GOAL 1-1:** The proportion of infants and children up to five years of age in the Women, Infants, and Children (WIC) Program with a hemoglobin of 11.5 gm/dl or less as registered at subsequent certification visits has been reduced by 4 percent.

OBJECTIVE 1-1: Reduce by 4 percent the proportion of infants and children up to the age of five years in the Special Supplemental Nutrition Program for WIC registering a hemoglobin of 11.5 gm/dl or less at subsequent certification visits.

BASELINE1-1: According to FY 1999 WIC participation data for the District of Columbia, the average percentage for low iron classification is 22 percent.

Overweight and obesity are leading health indicators.

RECOMMENDED ACTION:

- Participants and their caregivers will be targeted as agents of change to improve iron levels.
- Nutrition education, iron-rich supplemental foods, and a commitment by the WIC participant to behavioral changes are necessary to achieve this goal.
- Each participant will have a hemoglobin or hematocrit determination performed at least once a year. Participants with low iron levels may have an additional test performed within a given year.

RATIONALE:

- Relevant nutrition education will be provided for each client and opportunities for each client to sample some of the iron-rich foods that can positively impact their iron level will be provided.
- Follow-up testing will permit both clinician and participant to keep track of progress.

STRATEGY:

- Nutrition education on the need for improved iron levels before, during and after pregnancy will be provided for each client.
- Iron-rich food sampling opportunities will be provided.
- · Follow-up testing of iron levels will be conducted on each client.

RESOURCE REQUIREMENTS:

- Sufficient registered dietitians,
- · Funding for innovative and culturally appropriate educational materials, and
- Staff for tracking and follow-up are necessary for success.

December 2002 TARGET: By December 2002, the proportion of infants and children under five years of age registering low iron levels in the blood will be decreased by 1 percent from 22 to 21 percent.

2) **2010 GOAL 1-2:** The rates for breast-feeding and the duration of breast-feeding among women enrolled in the WIC Program in the District of Columbia have been increased to 35 percent.

OBJECTIVE 1-2: Increase to 35 percent the proportion of low-income residents enrolled in the Women, Infants and Children (WIC) program who breast-feed their babies in the early postpartum period and increase to at least 15 percent the proportion breast-feeding until their infants are six months old.

BASELINE 1-2: According to 2000 WIC data, currently 37 percent of women enrolled in WIC initiate breast-feeding, but only 10 percent continue the practice past six months postpartum.

RECOMMENDED ACTION:

Face-to-face contacts for breast-feeding education during pregnancy and after pregnancy are recommended. Each contact will consist of individual assessment, counseling and referrals.

- 95 percent of all pregnant WIC participants will receive at least one contact for breast-feeding education during pregnancy.
- 95 percent of postpartum participants will receive at least two contacts.

RATIONALE:

- According to the former Surgeon General, Dr. David Satcher, who sponsored the Health and Human Services Blueprint for Action on Breast-feeding, infants who are breast-fed experience a lower incidence of infections, have an enhanced immune system, and are at reduced risk for chronic diseases.
- Improved maternal health and societal benefits are also strong reasons to increase the incidence and duration of breast-feeding.

STRATEGY:

- The WIC Program will utilize registered dietitians, lactation consultants, and peer counselors to educate WIC families about the importance of breast-feeding.
- Educators will use creative, culturally appropriate education strategies.

RESOURCE REQUIREMENTS:

- Strong partnerships with local birthing centers, hospitals, and local breast-feeding groups will ensure that all available resources are tapped.
- WIC will require sufficient staff, including peer counselors who can make home visits and otherwise educate participants in a private setting.

DECEMBER 2002 TARGET: By December 2002, 31 percent of clients will breast-feed their babies in the early postpartum period and at least 11 percent will continue until the baby has reached 6 months of age.

3) **2010 GOAL 1-3:** Seventy-five percent of WIC participants presenting for a second nutrition contact are taught about the health hazards of obesity and the benefits of good nutrition and regular exercise as life-long prevention strategies in a section on obesity in the core WIC Education Curriculum.

OBJECTIVE 1-3: Reach 75 percent of WIC participants with lessons on obesity and the benefits of good nutrition and regular exercise in a section on obesity in the WIC core curriculum.

BASELINE1-3: As of 2001, WIC participants are not being taught about obesity, its long-term adverse affects on health and preventive strategies, since no section on obesity is included in the WIC core curriculum. However, based on WIC reports, approximately 10 percent of all participants are documented as being at or above the 95th percentile in weight for height.

RECOMMENDED ACTION:

- A section on obesity, its long-term implications for health, and the benefits of good nutrition and regular exercise as preventive strategies should be developed for inclusion in the WIC core curriculum which all WIC participants will receive.
- A proposed schedule of events is the following:
 - > Additions to the core curriculum by June 2002.
 - Pilot testing of curriculum done by July 2002.
 - > Training provided to nutritionists by September 2002.
 - Implementation by October 2002.

RATIONALE:

- Obesity has become one of the major nutrition-related issues facing our nation, because of its long-term adverse implications for health.
- Left unchecked, the increasing incidence of obesity among children as well as adults can negatively impact rates of diabetes and cardiovascular disease.

STRATEGY:

- Develop a section on obesity for inclusion in the WIC core curriculum and
- Use as a teaching guide to ensure that all participants are instructed about obesity, the significance of its threat to health and the benefits of good nutrition and regular exercise in lowering the risks for heart disease, diabetes and weight-related disorders.
- · The following strategies should be included:
 - > WIC participants should be encouraged to eat balanced meals.
 - > All participants should undergo regular weighing on-site at certification visits.
 - > Participants should be strongly encouraged to adopt the preventive strategies presented in the WIC core curriculum.

RESOURCE REQUIREMENTS:

Funding for the development and testing of educational and promotional materials.

DECEMBER 2002 TARGET: By December 2002, a chapter on obesity will be inserted in the WIC core curriculum, and clients are being counseled on well-balanced diets and the need to maintain a healthy weight, as well as proper diet variety and quantity.

Tobacco Use

Focus Area: Tobacco Use

1) **2010 Goal 2-1:** No more than 18.5 percent of adults are current smokers.

OBJECTIVE 2-1.1: Reduce to 18.5 percent the proportion of adults (18 years or older) who are current smokers.

BASELINE 2-1.1: 20.9 percent of adults were current smokers in the District of Columbia in 2000. (Behavioral Risk Factor Surveillance Survey or BRFSS)

Tobacco use is a leading health indicator.

RECOMMENDED ACTION:

- In the federal *Healthy People 2010 Plan*, the goal for addressing Tobacco Use is a reduction in illness, disability, and death related to tobacco use and exposure to second hand smoke.
- Recommendations include: anti-smoking educational campaigns designed to bring about behavior modification resulting from changes in the attitude and behavior of smokers as they become aware of the health risk and burden of disease associated with smoking.
- Determination of the level of knowledge among current smokers concerning the adverse health effects of smoking.

RATIONALE:

- Tobacco use is the single most preventable cause of death and disease in our society (Surgeon General's Report in 2000).
- In 1997, the death rate from lung cancer in the District of Columbia was 40.8 per 100,000 people compared to the national average of 37.3 per 100,000 people. Death rates from lung cancer are among the clearest indicators of the burden of tobacco use.
- Tobacco use is addictive and consequently, it is very difficult to quit smoking. Smokers often
 need education, counseling and/or medical intervention to overcome their addiction to tobacco
 and nicotine.

STRATEGY:

- Provide anti-tobacco educational materials to District residents.
- Promote smoking cessation programs in the community and coordinate efforts with current cessation programs through promotions and incentives for attendees.
- Produce and promote an interactive Internet commercial on the benefits of quitting smoking.
- · Promote cessation Hotline services.
- Implement an environmental tobacco smoke (ETS) campaign with emphasis on the dangers of second-hand smoke.

RESOURCE REQUIREMENTS:

- Continuation of the Comprehensive State-based Tobacco Use Prevention and Control Program funded by the federal Centers for Disease Control and Prevention (CDC).
- Continued partnership with Community Voices and the Tobacco Advisory Board (TAB).
- Utilization of appropriated funds from the Tobacco Master Settlement Agreement.

DECEMBER 2002 TARGET: As of December 2002, 11,000 of the adult population will be reached through anti-smoking educational campaigns.

- 2) **2010 GOAL 2-1.2:** No more than 15 percent of youth in the District of Columbia are current smokers.
 - **OBJECTIVE 2-1.2:** Reduce to 15 percent the proportion of youth (under 18 years of age) who are current smokers in the District of Columbia.
 - **BASELINE 2-1.2:** Seventeen percent of youth in the District of Columbia were current smokers in 1999 (Youth Risk Behavior Survey or YRBS).

RECOMMENDED ACTION:

Prevention efforts traditionally concentrate on bringing about a change in the attitudes and behaviors of youth who are current smokers

RATIONALE:

- Smoking is estimated to cause 4,927 District of Columbia residents to die prematurely (CDC Investment in Tobacco Control State Highlights 2001).
- Tobacco use among young people remains one of the most critical health priorities (Surgeon General's Report 2000).

- Cigarette smoking among friends, peers, siblings and others from the young person's immediate environment is consistently associated with smoking initiation.
- The influence of friends and peers seems to have considerable influence on youth attitudes and decisions regarding smoking.

STRATEGY:

Prevent youth smoking initiation by implementing the following activities:

- Conduct workshops for youth groups on the hazards of tobacco use.
- Administer the Youth Tobacco Survey in the District's Public Schools at the Junior High, Middle School, and High School levels.
- Publish the results of the survey.
- Implement an "antibeedies" campaign.

RESOURCE REQUIREMENTS:

- Continuation of the Comprehensive State-based Tobacco Use Prevention and Control Program funded by the CDC.
- Continued partnerships with the District's Public Schools, recreation centers, organizations that provide services for youth, and the TAB.
- Partnership with the American Legacy and W.A.Y. Too Cool to Smoke Program.

DECEMBER 2002 TARGET: As of December 2002, 4000 of the youth population will be reached through educational anti-smoking campaigns, including workshops and youth-led activities.

PROMOTE HEALTHY AND SAFE COMMUNITIES

- 3. Environmental Health and Food Safety
- 4. Injury/Violence Prevention
- **5. Pediatric Dental Health** (to be included in the AIP for 2003)

Environmental Health

Focus Area: Environmental Health

1) **2010 GOAL 3-2:** No screenings of District children result in blood lead levels in excess of 25 ug/dL and no more that 1 percent have blood lead levels exceeding 15 ug/dL.

OBJECTIVE 3-2: Reduce in children ages 6 months to 6 years, the prevalence of blood lead levels in excess of 15 ug/dL and ensure that no District child in this age group has a blood lead level in excess of 25 ug/dL.

BASELINE: 3-2: It is estimated that 1,516 or 3 percent of District children had blood lead levels exceeding 15 ug/dL, and 1,011 or 2 percent had blood lead levels exceeding 25 ug/dL in Fiscal Year 1999.

Environmental quality is a leading health indicator.

RECOMMENDED ACTION:

- Ensure that property owners provide lead-safe homes in any dwelling where a child under the age of six resides or visits.
- Continue to promote and provide free blood lead screening services.

RATIONALE:

• The District possesses an aging housing stock of which 95 percent of residences were built prior to 1978; the use of lead paint in residences was not banned until 1978.

STRATEGY:

- Educate property owners about lead-safe practices by dissemination of information.
- Perform lead inspection of residences where children 6 months to 6 years of age reside or visit.
- Disseminate materials through preschools and daycare centers.
- Increase education and outreach activities on this topic.
- Provide free screening using various sites.

RESOURCE REQUIREMENTS:

- Full staff capacity,
- · Equipment and
- Supplies

DECEMBER 2002 TARGET: By December 2002, there will be 22,000 screenings of children in the 6 months to 6 years age group.

2) **2010 GOAL 3-7:** All NPL waste sites in the District have been remediated.

OBJECTIVE 3-7: Eliminate significant health risks from the National Priority List (NPL) of hazardous waste sites, as measured by performing a level of site cleanup sufficient to eliminate the immediate and significant health threats as specified in the site's health assessments.

BASELINE 3-7: Nationally, 1,079 sites were on the NPL list in March of 1990; of these, health assessments have been conducted for approximately 1,000.

RECOMMENDED ACTION:

Continue the District's active participation in the Navy Yard clean-up as detailed in the Federal Facility Agreement entered into by the District, the federal Environmental Protection Administration EPA), and the Navy.

RATIONALE:

Only one NPL site is in the District, the Washington Navy Yard.

STRATEGY:

- Continue participation in the Tier I/ Tier II partnering process with the Navy, EPA and the remediation contractors.
- Continue to review planning and analysis documents as the Navy and its contractors develop them.
- Participate in other Anacostia River clean-up organizations, such as the Anacostia Watershed Toxics Alliance to ensure that Navy Yard information is incorporated into final decision documents.

RESOURCE REQUIREMENTS:

- · Full staff capacity,
- · Equipment and
- Supplies

DECEMBER 2002 TARGET: By December, 2002, review all planning and analysis documents submitted by the Navy and its contractors.

3) **2010 GOAL 3-11:** The District has adopted and implemented the 1999 National Food Code for institutional food operations and the new uniform food protection code for regulation of all District food operations.

OBJECTIVE 3-11: Adopt and implement the 1999 National Food Code for institutional food operations and the new uniform food protection code that sets recommended standards for regulation of all District food operations.

BASELINE 3-11: Two percent of states and territories, excluding the District of Columbia, had implemented the 1999 Food Code for institutional food operations in 1994.

RECOMMENDED ACTION:

Begin to implement the new food industry regulations that support the adopted National Food Code legislation passed by the District City Council in July of 2001.

RATIONALE:

It has been thirty years with no updates in the District's laws relating to the food industry.

STRATEGY:

- Use new innovative inspection procedures that ensure the cleanliness of the facilities.
- Distribute materials to the regulated community informing them of the new laws.

RESOURCE REQUIREMENTS:

- Full staff capacity,
- Equipment and
- Supplies

DECEMBER 2002 TARGET: By December, 2002, The Food Protection Division will have distributed 4,000 to 7,000 pieces of literature informing the regulated community of changes in the law and will additionally conduct over 10,000 inspections of food establishments to enforce these changes.

Injury/Violence Prevention

Focus Area: Injury and Violence

- 1) **2010 GOAL 4-6.1:** An Injury Registry has been established at the Department of Health (DOH) to which data on injury cases from hospital emergency rooms, trauma centers, and ambulatory clinics are reported on a regular basis.
 - **OBJECTIVE 4-6.1:** Establish an Injury Registry at the Department of Health (DOH) to which data on injury cases seen at hospital emergency rooms, trauma centers and ambulatory clinics are reported on a regular basis.
 - **4-6.1a:** Submit legislation entitled "Injury Reporting Bill" mandating development of an Injury Registry at DOH to General Counsel's Office for review and enactment by City Counsel.
 - **4-6.1b:** Upon approval, notify administrators of (all District-based) injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) of the establishment of an Injury Registry in the District of Columbia located within DOH.
 - **4-6.1c:** Assist in the drafting of regulations by General Counsel's Office and alert trauma treatment center administrators to announcement of regulations in the DC Register.
 - **4-6.1d:** Send official notification of establishment of Injury Registry and regulations mandating reporting to DOH to all trauma treatment sites in the District of Columbia.
 - **4-6.1e:** (1) In the interim, establish Advisory Committee to oversee the design and data intake and storage capability of the Injury Registry.
 - (2) Establish Memoranda of Agreements with (all District-based) injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to voluntarily submit injury information to the DOH Injury Registry prior to the passing of the "Injury Reporting Bill."
 - **4-6.1f:** Hire and train the staff (data manager and two data entry clerks) for the Registry.
 - **BASELINE 4-6.1:** As of July, 2001, there is no Injury Registry at DOH to which data are reported on a regular basis. Baseline data regarding the steps leading to the establishment of the Registry are to be added.

Injury and violence are among the leading health indicators.

RECOMMENDED ACTION:

Development and submission to Office of Legal Counsel of legislation establishing the Injury Registry at DOH:

- Submit an "Injury Reporting Bill" to Office of the Legal Counsel for review and submission to City Council for approval and enactment:
 - > Mandating the formation of an Injury Registry at DOH to contain data on intentional and unintentional injuries to District residents;
 - > Mandating injury treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to report all injuries to the DOH; and
 - > Specifying regulations for the regular reporting on cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics.
- Establish Memoranda of Agreement with injury-treatment sites (hospital emergency rooms, trauma centers, and ambulatory clinics) to voluntarily submit injury information to DOH prior to the passing of the legislation.
- Develop an Injury Registry Task Force comprised of professionals with expertise in injury, as well as disability, for both pediatric and adult patients.

RATIONALE:

The establishment of an Injury Registry at DOH will permit:

- Regular reporting to the public on the incidence and types of injury trauma suffered by residents;
- Development of epidemiological studies regarding the nature and origin of the various types of injuries; and
- · Provision of information on injuries upon which the strategic planning of emergency response mechanisms can be based.

STRATEGY:

- Utilize the Injury Registry Advisory Team to review the current "Injury Reporting Bill" and develop an impact statement for City Council consideration.
- Revise the "Injury Reporting Bill" to include the recommendations of the Advisory Team.
- Submit the proposed "Injury Reporting Bill" to the Office of the Legal Counsel for review and submission to the City Council for consideration and enactment.
- Develop Memoranda of Agreement with the injury treatment sites (i.e., hospital emergency) rooms, trauma centers and ambulatory clinics) for the purpose of reporting injury data to the DOH on a voluntary basis prior to the enactment of the legislation.
- Utilize the intentional injury surveillance database as the initial information for the Injury Registry.
- Work with the Advisory Team to develop an enforcement clause for consideration by the City Council.

RESOURCE REQUIREMENTS:

- Hire staff data manager and two (2) data entry clerks.
- Budget line item for staff salaries and fringe benefits.
- Budget line item to maintain registry (including software, equipment and maintenance).
- Budget line item for staff training.
- Budget line item for Information Technology (IT) assistance from the State Center for Health Statistics Administration.
- Budget line item for report analysis, development and dissemination.

DECEMBER 2002 TARGET: By December 2002, the process of establishing an Injury Registry at the DOH will be 85 percent complete. This percentage takes into consideration the time required for the legislative processing by the DOH Office of the Legal Counsel and the City Council.

- 2) **2010 GOAL 4-6.2:** Ninety percent of hospital emergency rooms, trauma centers, and ambulatory clinics in the District of Columbia report data on injury cases seen on-site to the DOH Injury Registry on a regular basis in compliance with the regulations.
 - **OBJECTIVE 4-6.2:** Increase to 90 percent the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data on intentional and unintentional injuries to residents seen to the DOH Injury Registry in compliance with the regulations.
 - **BASELINE 4-6.2:** Baseline data to be determined. All level one trauma centers (of which there are three) have registries that collect data on the external causes of injury, but are not mandated to report this information to the DOH. The number of treatment sites voluntarily reporting data to the DOH on intentional and unintentional injuries seen on-site can be considered as a baseline to which more sites can be added after reporting becomes mandatory.

RECOMMENDED ACTIONS:

Memoranda of Agreement outlining collaboration and commitment of the Bureau of Epidemiology and Health Risk Assessment, DOH Emergency Medical Services Administration, State Center for Health Statistics Administration, Metropolitan Police Department, and DC Fire and Emergency Medical Services Department and the Office of the Medical Examiner in the reporting of injury information regarding both mortality and morbidity.

RATIONALE:

- Information obtained from the Injury Registry will allow the DOH to make recommendations to
 policymakers and trauma care facility management planners to make decisions on resource
 allocations within in the various city wards.
- The establishment of an Injury Registry at DOH will enable the government to inform District residents of the ongoing trends in intentional and unintentional injuries in terms of extent of morbidity and mortality.

STRATEGY:

- Create an Injury Registry Task Team to assist in assessing the completeness of current reporting.
- Assess the data coding practices of all hospital emergency rooms, trauma centers, and ambulatory clinics.
- Assess the database (i.e., software) of each hospital emergency room, trauma center, and ambulatory clinic for compatibility.
- Select appropriate software for the Injury Registry system that will allow the electronic linkage of information between the DOH and treatment sites (hospital ER, trauma center, and ambulatory clinic).
- Develop a uniform reporting system for trauma injuries that will be mandatory for all trauma treatment sites (hospital ER, trauma centers, and ambulatory clinics).
- Mandate the reporting of all trauma injuries to the DOH by District hospitals, trauma centers, and ambulatory clinics.

RESOURCE REQUIREMENTS:

- Legislation that mandates the regular reporting by all District of Columbia hospital emergency rooms, trauma centers, and ambulatory clinics of intentional and unintentional injury cases seen on-site to the Injury Registry at the DOH.
- The inclusion of funding in the District of Columbia budget that ensures the sustainability of the Injury Registry at the DOH.
- Hire Staff Data Manager and two (2) Data Entry Clerks.
- Budget line item for staff salaries and fringe benefits.
- Budget line item to maintain registry (including software, equipment and maintenance).
- Budget line item for staff training.
- Budget line item for IT assistance.
- Budget line item for report analysis, development and dissemination.

DECEMBER 2002 TARGET: By December 2002, 85 percent of the injury treatment sites report data to the DOH Injury Registry by one of the following mechanisms: 1) as mandated by the enactment of the "Injury Reporting Bill" or 2) voluntarily through Memoranda of Agreements stating their commitment to participate in the reporting.

Pediatric Dental Health

This focus area program is under development and will be included in the next Annual Implementation Plan.

EXAMPLE:

Focus Area: Pediatric Dental Health

GOAL 5-3: At least 70% of children in the 8 year old and 14 year old age groups have received protective sealants in permanent molar teeth.

OBJECTIVE 5-3: Increase to at least 70% the percentage of children in the 8 year old and 14 year old age groups who have received protective sealants in permanent molar teeth.

BASELINE 5-3: Nationally, between 1988 and 1994, 23% of 8-year-olds and 24% of 14 year-olds received sealants in permanent molar teeth.

RECOMMENDED ACTION:

(To be added by program staff)

RATIONALE:

(To be added by program staff)

STRATEGY:

(To be added by program staff)

RESOURCE REQUIREMENTS:

(To be added by program staff)

DECEMBER 2002 TARGET: By December 2002, the proportion of District children who have received protective sealants in permanent molar teeth has increased from -percent for 8 year olds and - percent for 14 years olds (local data to be added; national baseline is 23% between 1988 and 1994) to - percent for 8 year olds and - percent for 14 year olds.



- 6. Primary Care
- 7. Emergency Medical Services
- 8. Health Care Finance
- 9. Maternal, Infant and Child Health and Family Planning
- 10. Public Health Infrastructure

Primary Care

Focus Area: Primary Care

1) **2010 GOAL 6-1:** Access to care has been increased by increasing the number of designated Health Professional Shortage Areas in the District of Columbia from 9 to 20.

OBJECTIVE 6-1: Increase access to care by increasing the number of Health Professional Shortage Areas (HPSA) in the areas of primary, dental and mental health care in the District of Columbia from 9 to 20.

BASELINE 6-1: In 2001 in the District of Columbia, there are 4 service areas, 2 population groups and 1 facility designated for primary medical care. There is 1 population group for dental health care and 1 service area for mental health care.

Access to Health Care is one of the leading health indicators.

RECOMMENDED ACTION:

- · Assess health care delivery services at the census tract level throughout the District of Columbia and
- Recommend health service areas for designation status to the Health Resources and Services Administration's Division of Shortage Designation.

RATIONALE:

HSPA designation status is necessary for National Health Service Corps. Provider placement, J-1 Visa waiver physician placement and some grant funding resources.

STRATEGY:

- Determine the population residing in census tracts by number of residents, economic status, and age.
- · Determine the number of primary care, mental health and oral health providers available to serve the populations residing in each census tract.
- Determine the population to provider ratio.
- Develop a study of the area which encompasses findings.
- Recommend designation status accordingly.

RESOURCE REQUIREMENTS:

- 2 FTEs for staffing needs
- Computer software and hardware for database information and report preparation.

DECEMBER 2002 TARGET: By December 2002, 2 primary care services areas, 1 dental care services area and 2 mental health services areas will be assessed and recommended for Health Professional Shortage Area (HPSA) designation.

2). **2010 GOAL 6.2:** Access to comprehensive, high-quality primary health care services has been improved by developing and implementing standards of care in certified primary health care facilities in the District of Columbia from 0 to 30.

OBJECTIVE 6.2: Improve access to care by developing and implementing standards of care in certified primary health care facilities in the District of Columbia from 0 to 30.

BASELINE: (Developmental) As of 2001, there are no monitored standards of care at the primary care level.

RECOMMENDED ACTION:

- Develop and implement standards of care for primary health care services delivered in the District of Columbia, and
- Establish a certification process that indicates that an organization is working towards or has met the standards of care.

RATIONALE:

The program would establish a new class of health care facility, which the District of Columbia would certify. The certified primary health care organizations would provide a wider safety net for health care delivery to low-income uninsured residents that do not qualify for Medicare or Medicaid.

STRATEGY:

- Clinics would voluntarily submit an application for consideration to the Primary Care Administration.
- Clinics enrolled in the program will be assessed for preparedness and provided with technical assistance, capacity-building grants and other services on a competitive basis.
- Upon meeting certification requirements, clinics will be certified.

RESOURCE REQUIREMENTS:

- 5 FTEs for administrative needs
- \$7.8 million for programmatic development over 4 years.

DECEMBER 2002 TARGET: By December 2002, there will be a developed set of standards of care for primary health care services delivered in the District of Columbia.

Emergency Medical Services

Focus Area: Emergency Medical Services

1) **2010 GOAL 7-7:** The Emergency Operations Plan for the District of Columbia has been developed and implemented.

OBJECTIVE 7-7: Continue participation in the development and update of the District's Emergency Operations Plan for response to current and new threats to the District of Columbia and surrounding jurisdictions.

BASELINE 7-7: Emergency Health and Medical Services (OEHMS) participation in the development of the Emergency Operations Plan for the District of Columbia began in 1999.

RECOMMENDED ACTION:

One of the major priorities for OEHMS is to:

Ensure that the Department of Health (DOH) responds appropriately and in a timely manner to emergency health incidents and other emergencies and disasters in the District of Columbia.

RATIONALE:

- The Emergency Operations Plan for the District of Columbia is modeled on the federal "Emergency Response Plan."
- The DOH is responsible for the chapter entitled the Emergency Support Function (ESF) #8 Health and Medical Services.
- The OEHMS is working with other DOH agencies and the DC Fire and EMS Department.
- Decision-making on the Plan is being done by consensus with the lead agency being the Emergency Management Agency (EMA).

STRATEGY:

- 1. The draft ESF8 chapter in the Emergency Operations Plan has been completed and is now out for public review.
- 2. The draft Emergency Operations Plan for the District of Columbia has been placed on the EMA website for review and information.
- 3. After public review, the Plan will go to the DC Council for approval.
- 4. The Plan will then go to Congress for the final review and release by June of 2002.
- 5. Due to recent events, DOH is already operating under the draft Plan.

RESOURCE REQUIREMENTS:

Funding is available. Additional personnel need to be hired.

DECEMBER 2002 TARGET: As of December, 2002, 100 percent of OEHMS tasks as participant in the District's Emergency Operations Plan will be accomplished.

Due to shifting priorities, OEHMS will be unable to work on the second objective in this implementation year.

Health Care Finance

Focus Area: Health Care Finance

1) **2010 GOAL 8-3:** Comprehensive Data Reporting System will be established (that will yield accurate, timely data for Health Care Financing decision making).

OBJECTIVE 8-3: Establish a comprehensive data reporting system to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations and provider types.

BASELINE 8-3: (Developmental): A twenty-plus year old Medicaid Management Information System (MMIS) system is currently the primary production system for the Medicaid program. A contract to procure a new system was signed this Spring and a transfer of a new MMIS is currently under way. There is also no current, separate analytical system for analyzing the data from the current MMIS.

RECOMMENDED ACTION:

Ensure that the implementation plan proceeds as scheduled for the planned transfer of the new system through using periodic status reports from the fiscal intermediary and using the monitoring contractor to review all MMIS implementation activities. A separate Health Insurance Portability and Accountability Act (HIPAA) of 1996 activity will identify any potential gaps in MMIS that would pose a problem for timely MMIS implementation, and implement and monitor the HIPAA remediation timetable for the MMIS.

RATIONALE:

 The strategic role of Medicaid in the financing of services to vulnerable, uninsured populations is central to ensuring the overall health of all District residents. To measure the impact and success of Medicaid's various programs and populations, will take a more sophisticated system for the collection and manipulation of Medicaid data.

STRATEGY:

- Review and update requirements for the MMIS.
- Monitor implementation plan for new system.
- Update set of system reports for the MMIS.
- Identify standard reporting information and distribution list.

RESOURCE REQUIREMENTS: Contained in the MMIS contract: staff, hardware and software requirements

DECEMBER 2002 TARGET: By December 2002, there will be established a fully-functioning, transferred and updated MMIS with a separate Data Warehouse for analyses.

2) **2010 GOAL 8-4:** Temporary Assistance to Needy Families (TANF)-related enrollees have a specified source for on-going primary care.

OBJECTIVE 8-4: Increase to 95% the proportion of all TANF-related enrollees who have a specified source of ongoing primary care (i.e., a medical/health home).

BASELINE 8-4: In 1998 there were approximately 87% of all TANF enrollees with a specified source of on-going primary care (e.g., being enrolled in one of the MAA-contracted managed care organizations (MCOs)).

RECOMMENDED ACTION:

Measure the percent of enrollees in the existing MCOs and the impact of the educational efforts of the enrollment broker in helping TANF recipients to choose an appropriate MCO.

RATIONALE:

Managed care is considered to be a viable way for Medicaid programs to cost-effectively provide primary care and related services for eligible individuals and families.

STRATEGY:

- Work with outreach initiatives to increase identification of eligible TANF enrollees.
- Use Enrollment Broker to improve education and orientation of new TANF enrollees.
- Measure monthly changes in the percentage of TANF enrollees in MCOs.

RESOURCE REQUIREMENTS:

The specific required resources are outlined in the Houston Associates Outreach contract and the Enrollment Broker contract.

- · Outreach contract
- · Enrollment Broker contract

DECEMBER 2002 TARGET: By December 2002, there will be reports of 95% or better in the proportion of TANF enrollees in an identified MCO.

3) **2010 GOAL 8-7:** Medicaid-eligible persons will have access to comprehensive behavioral health services (i.e., mental health and substance abuse services).

OBJECTIVE 8-7: Collaborate in the creation of an integrated services delivery system which assures that Medicaid eligible persons have access to comprehensive behavioral health services.

BASELINE 8-7: (Developmental). Currently, mental health services are provided by several different institutional provider types and individual licensed practitioners of the healing arts. But there is not an integrated system of care for both mental health and substance abuse services.

RECOMMENDED ACTION:

Work with the new Department of Mental Health and APRA to develop an integrated system for behavioral health services funded by Medicaid.

RATIONALE:

It is not cost-effective to provide fragmented care to persons needing behavioral health services. Services can be provided more cost-effectively and coordinated better in an integrated system.

STRATEGY:

- Develop SPAs for set of behavioral health services in the mental health and Substance abuse areas.
- Develop appropriate rates for the services
- Develop appropriate standards and criteria for services review

RESOURCE REQUIREMENTS:

Contract for SPA development, rate development and standards and criteria development.

DECEMBER 2002 TARGET: By December 2002, at least 65 percent of persons accessing behavioral health services will be in an integrated health delivery system.

Maternal, Infant and Child Health and Family Planning

Focus Area: Maternal, Infant and Child Health and Family Planning

1) **2010 GOAL 9-1:** The infant mortality rate has been reduced to no more than 8 per 1,000 live births.

OBJECTIVE 9-1: Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births.

BASELINE 9-1: The infant mortality rate was 15.0 per 1,000 live births in 1999.

Responsible sexual behavior is one of the leading health indicators.

RECOMMENDED ACTION:

- Early and regular prenatal care must be obtained. Programs must increase their outreach capacity and take the initiative to find and educate women about the importance of care.
- In addition, programs must forge strong referral relationships between prenatal services and other programs that are in touch with potential clients. An example of this is with the WIC Program.
- The Institute of Medicine recommends reducing the risk before conception. This can be achieved by providing pre-pregnancy counseling, stressing a healthier woman and the importance of having and maintaining a healthy lifestyle prior to pregnancy.

RATIONALE:

- Infant mortality is a marker for the overall health of a community. Between 1990 and 1999, the infant mortality rate has dropped by 25% in the District of Columbia.
- However, there was a marked increase in the infant mortality rate in 1998, and it still remains twice as high as the national rate.
- In addition, great disparities exist between racial and ethnic population groups in this area.

STRATEGY:

- Increased outreach activities to identify at risk pregnant women and infants. This includes working with internal and external agencies such as WIC and non-profit organizations.
- Intensive home visiting to ensure pregnant women and infants receive care and the implementation of the Newborn Home Visiting Initiative.

Maternal, Infant and Child Health and Family Planning

- Working with Medicaid and other health care providers to ensure everyone is taking a proactive approach to reducing infant mortality and Improving health outcomes by stressing changing attitudes and
- Promoting lifelong healthy lifestyle practices and behaviors.

RESOURCE REQUIREMENTS

- Additional local dollars to fully fund the Newborn Home Visiting Initiative, and
- Coordination with other home visiting programs throughout the city in order to avoid duplication of effort and leverage available resources.

DECEMBER 2002 TARGET: As of December, 2002, the infant mortality rate will have been decreased from 15.0 in 1999 to 13.0 per 1,000 live births.

2) **2010 GOAL:** The proportion of all pregnant women who begin prenatal care in the first trimester is increased to 80 percent.

OBJECTIVE: Increase to at least 80 percent the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.

BASELINE: In 1999, 68.8 percent of all District of Columbia resident births were to women who began prenatal care in the first trimester.

RECOMMENDED ACTION:

- Early and regular prenatal care must be obtained. Research has shown that the chance of a women having a healthy birth outcome is increased the earlier she obtains prenatal care.
- Programs must increase their outreach capacity and take the initiative to find and educate women about the importance of care.
- Programs targeted at getting high-risk, hard-to-reach women into prenatal care early should be culturally sensitive.

RATIONALE:

- Several barriers to accessing prenatal care have been identified through the years. These include inadequate transportation and childcare services, the systemic inadequacy in recruiting hard-to-reach women and the lack of insurance to pay for prenatal care.
- Other factors have also contributed to women not obtaining care early, including lack of information about the importance of early care and dissatisfaction with health care providers.

• In addition, great disparities exist between racial and ethnic population groups, with African-American women being least likely to obtain care in the first trimester when compared to their white counterparts.

STRATEGY:

- Increase outreach activities to identify women who are pregnant early in their pregnancy and encourage entry into prenatal care.
- Launch intensive public information campaign that stresses the importance of early entry into prenatal care.
- Work with medical providers to alleviate access issues for pregnant women.
- Encourage maximum use of the Medicaid program (for pregnant women).
- Improve reporting of entry into prenatal care on the birth certificate.

RESOURCE REQUIREMENTS:

- Additional funds to conduct a comprehensive and coordinated public information campaign.
- Coordinate current resources (funding, personnel, etc.) throughout the city to conduct extensive outreach activities focused on identifying pregnant women and getting them into care early.

DECEMBER 2002 TARGET: As of December 2002, 71 percent of all District of Columbia resident births are to women who began prenatal care in the first trimester.

3) **2010 Goal 9-19:** All newborns are screened for hearing loss prior to hospital discharge.

OBJECTIVE 9-19: Increase to 100 percent the proportion of newborns that are screened for hearing loss by one month of age, have diagnostic follow-up by three months and are enrolled in appropriate intervention services by six months.

BASELINE 9-19: In 1999, 70 percent of all newborns born in the District of Columbia were screened for hearing impairments before hospital discharge.

RECOMMENDED ACTION:

- Early identification of hearing loss in newborns is essential.
- All hospitals and birthing centers must ensure that newborns are screened prior to discharge and rescreened, if the test comes back inconclusive or positive for hearing loss.
- Once a child is identified as having a hearing impairment, all entities (i.e. insurance provider, primary care physician, and the Department of Health) should work with the family to assure that the child receives the proper follow-up services.

RATIONALE:

- The impact of hearing loss on early language development has been well documented.
- Research has shown that early identification followed by intervention before six months of age
 results in normal language at age three, in contrast to two- to four- year delays in language
 development as seen in children whose impaired hearing is identified late.

STRATEGY:

- Complete rulemaking for the recently passed District of Columbia Law 13-276, the Newborn
 Hearing Screening Act of 2000, which mandates that hospitals screen all newborns for hearing
 impairments.
- Work with hospitals to ensure that they have the necessary equipment (including the Management Information Systems or MIS tracking program) to conduct hearing screenings on all newborns.
- Establish referral network for all newborns needing the appropriate follow-up services.
- Provide follow-up for uninsured infants.

RESOURCE REQUIREMENTS:

- Federal grant funds have been identified to assist with the implementation of the newborn hearing screening programs.
- Additional funds need to be identified that can be used to purchase ear molds for children.
- Coordination with the Office of Early Childhood Intervention to deliver follow-up services for infants identified with hearing impairments and needing additional assistance.

DECEMBER 2002 TARGET: As of December 2002, all infants born in the District of Columbia will have been screened for hearing impairments and the appropriate follow-up steps have been taken for those needing additional services.

Public Health Infrastructure

Focus Area: Public Health Infrastructure

1) **2010 GOAL 10-3:** Data are accessible at the SCHSA on all (100 percent) of the population groups residing in the District.

OBJECTIVE 10-3: Develop data on all (100 percent) racial/ethnic population groups residing in the District (Black, white, Hispanic /Latino, Asian American/ Pacific Islander, American Indian/ Alaska Native).

BASELINE 10-3: As of April 2001, data on three broad racial population groups (black, white, other) residing in the District are available in reports routinely produced by the SCHSA.

RECOMMENDED ACTION:

Recognizing the need for greater consistency in tracking population group, the developers of the federal Healthy People 2010 Plan, adopted the federally designed minimum template for all Healthy People 2010 population-based objectives. The minimum template for all population-based objectives is as follows:

Race:

American Indian or Alaska Native

Asian or Pacific Islander:

Asian

Native Hawaiian or Other Pacific Islander

Black or African American

White

(Ethnic origin) Hispanic origin:

Hispanic or Latino

Black or African American

White

Gender:

Female Male

Socioeconomic status:

Family income level Education level

Poor Less than high school Near poor High school graduate Middle/ high income At least some college.

RATIONALE:

- Provision of data for all population groups is essential for the monitoring of health status to
 identify community health problems and the diagnosis and study of health problems and hazards
 in the community, both of which are essential public health services.
- Data sets for each of the racial and/or ethnic population groups residing in the District are essential for the identification and tracking of health disparities and of any progress made in the elimination of disparities.

STRATEGY:

- In June of 2002, the DOH/SCHSA was awarded the services of a Prevention Specialist who will
 join the team on the 2010 Work Group in late August to organize and manage a citywide
 community health status assessment that will provide descriptive data on all racial and ethnic
 population groups residing in the District, as well as baselines against which progress in
 eliminating disparities can be measured.
- The SCHSA health statisticians in the 2010 Work Group and the Healthy People 2010 Program
 Liaisons working with their Advisory Groups can and will assemble most of the available health
 program related data on residents of the District of Columbia. The SCHSA group can provide
 basic descriptive data on residents through its access to data on births and deaths, health status
 indicators, and socioeconomic data (from the Office of Planning) needed to develop health
 profiles of the various racial and ethnic population groups residing in the District of Columbia.
- There are at least three key community assessment tools available for use via the Internet (The Public Health Foundation's *Tool Kit*, the federal Office of Disease Prevention and Health Promotion's *Healthy People in Healthy Communities, a community planning guide*; and the National Association of County and City Health Officials' *Mobilizing for Action through Planning and Partnerships* or MAPP process). All contain stepwise procedures for data collection and recommended strategies in preparation for community interventions while stressing the building of key coalitions and solid partnerships. The identification and recruitment of key partners, particularly among the resident minority population groups, for the planning and development of the citywide community health assessment process, is already underway at the SCHSA.
- The members of the Healthy People 2010 focus area program staff and their community-based organizations liaisons can and will provide community access and program related data on the five resident population groups, as well as access to key partners at the community level.
- Proposed steps in the development of a reference library of resident minority health data include the following:

- Review of available data sets currently available at the SCHSA on residents for completeness and accuracy and catalogue according to the five racial/ethnic population groups.
- Contact known community-based sources of local data and request access to missing information.
- Develop catalogued data sets of demographic, morbidity, mortality, and socioeconomic data for all population groups residing in the District and make the data sets accessible to 2010 focus area program staff and other interested researchers into minority health.

RESOURCE REQUIREMENTS:

- Additional statisticians, possibly a graduate student in biostatistics to organize the available data in charts and tables by population group and to collect additional data from community-based organizations.
- Funding to support personnel.

DECEMBER 2002 TARGET: By December, 2002, 25 percent of descriptive data (i.e. demographics, socioeconomic status, education levels, employment status, insurance coverage, mortality and morbidity) on at least three of the five resident population groups in the District should be available for researchers into health disparities among residents.

- 2) **2010 GOAL 10-1:** 90 percent of DOH agencies provide onsite access to data via electronic systems and online information systems.
 - **OBJECTIVE 10-1.1:** Increase to 90 percent the proportion of DOH agencies that provide onsite access to data via electronic systems and online information systems such as the Internet.
 - **BASELINE 10-1.1:** Zero in 1997. DOH agencies had no access to the internet at this time. By 2001, this goal had been met. All of the major sites at DOH –around 1200 employees are connected via electronic systems and online information systems and have internet access.

RECOMMENDED ACTION:

• This objective was a direct application of the federal *Healthy People 2010 objective 23-1*: Increase the proportion of Tribal, State, and local public health agencies that provide Internet and e-mail access for at least 75 percent of their employees and that teach employees to use the Internet and other electronic information systems to apply data and information to public health practice.

RATIONALE:

- The justification provided for national objective 23-1 applies here: "All workers within a State or local public health agency need access to the Internet or other electronic information systems appropriate to their job functions."
- Access requires hardware, software that can browse the Internet and can be used to analyze health information Databases, and training on the effective use of the Internet and database systems.
- Key to meeting this objective are: adequate capacity in public health informatics the systematic
 application of information and computer science and technology to public health practice,
 research, and learning.

STRATEGY:

- Systematic installation of computer systems and requisite software, as well as training
 opportunities, that will permit all DOH offices and agencies onsite access to data via electronic
 systems and online information systems, in addition to the Internet.
- Installations were completed as of June, 2001. Training was conducted by Knowlogy Corporation (professional trainers in electronic systems and use of assorted software) and was open to all DOH employees until the beginning of 2001.

RESOURCE REQUIREMENTS:

- Information technology team adequately trained and staffed to complete the installations.
- Adequate amounts of computers and printers for employees.
- Funding to support personnel and equipment.

PROGRESS REPORT IN 2001 - TARGET ALREADY ATTAINED:

As of July, 2001, 100 percent of DOH agencies have onsite access to data via electronic systems and online information systems.

PREVENT AND REDUCE DISEASES AND DISORDERS

- 11. Asthma
- 12. Cancer
- 13. Diabetes
- 14. Disabilities
- 15. Heart Disease and Stroke
- 16. HIV/AIDS
- 17. Immunization
- 18. Mental Health and Mental Disorders
- 19. Sexually Transmitted Diseases
- 20. Substance Abuse
- 21. Tuberculosis

Asthma

Focus Area: Asthma

1) **2010 Goal 11-1:** Asthma death rate is reduced to no more than 1.5 per 100,000 residents.

Objective11-1: Reduce the asthma death rate to no more than 1.5 per 100,000 population.

Baseline 11-1: The asthma death rate was 2.8 per 100,000 residents for all ages in 1997.

Recommended Action:

- Increase the level of awareness and knowledge of the triggers, signs and symptoms and treatment strategies for asthma in the general population, persons with asthma and their caregivers.
- Increase access to healthy environments and education programs that will allow more effective management of this condition.

Rationale:

- Reducing asthma mortality rates will require more effective management of the condition by health care providers and persons with asthma and their families.
- Education programs for patients, especially children with asthma, can help to decrease asthma mortality, as well as asthma morbidity, and the utilization of hospital services for asthma management.

Strategy:

- Improve the current training available for and knowledge of asthma signs and symptoms, medications and asthma triggers by providing healthcare provider seminars, presentations, and fact sheets.
- Expand the current "Open Airways," a school-based education program, to additional areas of the city for representation in the four Wards with the highest asthma incidence.
- School-based education programs will be implemented through planned collaborations with school health programs and the American Lung Association of the District of Columbia (ALADC).
- Increase the knowledge and use of national asthma prevention and control strategies by dissemination and monitoring of accepted asthma management guidelines.

Resource Requirements:

- Recommendations for changes in the training of health professionals to emphasize the awareness of asthma triggers, signs and symptoms, and treatment strategies.
- Experts in the Advisory Committee will be asked for recommendations and evaluation of asthma planning priorities and goals.

DECEMBER 2002 TARGET: By December, 2002, the asthma death rate has decreased by 0.1 per 100,000 residents per year for all ages.

Cancer

Focus Area: Cancer

Lung Cancer

1) **2010 GOAL 12-1:** Mortality from lung cancer in the District of Columbia has been reduced to an age-adjusted rate of 40.2 per 100,000 residents.

OBJECTIVE 12-1: Reduce lung cancer mortality in the District of Columbia to an age-adjusted rate of no more than 40.2 per 100,000 residents.

BASELINE 12-1: The age-adjusted lung cancer death rate in the District in 1997 was 46.7 per 100,000 residents.

RECOMMENDED ACTION:

- Increase smoking cessation and reduction education and programs targeted to youth and addicted young adults.
- Encourage and educate providers to reinforce smoking cessation and offer cessation tool, especially to Hispanic and African American, young adults

RATIONALE:

- Lung cancer is the most common cause of cancer death among both females and males in the United States.
- It is the leading cause of cancer deaths in the District of Columbia.
- Tobacco use is the single most preventable cause of death in the society and is the most important risk factor for lung cancer in the District.
- After 10 years of abstinence, smoking cessation decreases the risk of lung cancer to 30 to 50 percent of that of continuing smoking.

STRATEGY:

- Increase the number of smoking cessation programs offered in the District of Columbia.
- Increase the number of smoking cessation programs available to Spanish speaking residents.
- Expand the availability of smoking cessation tools (patch, pills, gum) free of charge to residents requesting smoking cessation aids.

- Provide improved quit line information on cessation assistance for residents requesting help for smoking cessation.
- Increase number of primary care providers who assess and incorporate smoking cessation messages in routine patient encounters.
- Increase availability of smoking cessation and anti-tobacco materials available in provider offices.

RESOURCE REQUIREMENTS:

District and grant funding for cessation tools, quit line maintenance, and brochure development and distribution.

DECEMBER 2002 TARGET: By December 2002, at least one smoking cessation class will be available in each ward of the city with a variety of cessation tools provided to those who require them.

Breast Cancer

1) **2010 GOAL 12-2.1:** Breast cancer mortality in the District has been reduced to an age-adjusted rate of no more than 24.4 per 100,000 residents.

OBJECTIVE 12-2.1: Decrease the age-adjusted mortality rate for breast cancer to no more than 24.4 per 100,000 residents.

BASELINE 12-2.1: The age-adjusted mortality rate for breast cancer in the District in 1997 was 29.1 per 100,000 residents.

RECOMMENDED ACTION:

- Early cancer detection saves lives by identifying tumors at an early stage of disease development when treatment is more effective and prognosis is most favorable.
- To detect breast cancer early, the American Medical Association recommends a clinical breast exam every three years for women 20- 39 years in age.
- Annual clinical breast examinations and mammograms are recommended for women 40 years of age and over.
- Uninsured or underinsured women need assistance in obtaining these early cancer detection services.

RATIONALE:

- Clinical breast exams and mammograms can detect cancer early and reduce mortality.
- Approximately 36,000 women are uninsured or underinsured in the District.
- Of these women, 13,000 are in the 40 64 years age range and in need of annual mammograms and clinical breast exams.

STRATEGY:

- In 2002, provide breast cancer education, through multi-media campaigns, one-on-one outreach, and group teachings, to at least 15,000 women in the District of Columbia.
- Provide free breast cancer screening and follow-up to at least 1,500 uninsured or underinsured District women at over 40 provider sites.
- Priority populations to be reached include African Americans, Hispanics, Asian/Pacific Islanders, lesbians, and women with disabilities.
 - > Utilize mass mailings twice per year to distribute educations information.
 - > Collaborate with local media to provide PSAs once per year.
 - Utilize metro rail and bus advertisement space to raise awareness about breast cancer once per year.
 - Utilize Peer Volunteer Program monthly to provide one-on-one outreach.
 - Conduct group education sessions monthly.
 - Collaborate with Project WISH network providers to ensure free screenings at over 40 contracted, local sites.

RESOURCE REQUIREMENTS:

• Funding from the federal Centers for Disease Prevention and Control (CDC) and the District government for health education, screening, and follow-up.

December 2002 TARGET: As of December 2002, (1) at least 15,000 District women will receive breast cancer education and (2) 1,500 uninsured and underinsured District women will receive free breast cancer detection services.

Cervical Cancer

1) **2010 GOAL 12-2.2:** Cervical cancer mortality in the District has been reduced to an age-adjusted rate of no more than 0.88 per 100,000 residents.

OBJECTIVE 12-2.2: Decrease the age-adjusted mortality rate from cervical cancer to no more than 0.88 per 100,000 residents

BASELINE 12-2.2: The age-adjusted cervical cancer mortality rate in the District in 1997 was 2.2 per 100,000 residents.

RECOMMENDED ACTION:

- The American Medical Association recommends that all women who are or who have been sexually active, or who have reached the age of 18, should have an annual Pap test and pelvic exam.
- After a woman has had three or more consecutive, satisfactory, normal annual exams, the Pap test may be performed less frequently at the discretion of a clinician.
- Uninsured or underinsured women need assistance in obtaining early cancer detection services.

RATIONALE:

- Cervical cancer mortality rates in the US have declined over 40% since the 1970s, in large part because of widespread use of the Pap test.
- The Pap test has reduced death rates by identifying cancerous and pre-cancerous cervical cells.
- Half of all women with newly diagnosed invasive cancer have not had a Pap test in the last five years.
- Approximately 36,000 District women are uninsured or underinsured and in need of a Pap test and pelvic exam.

STRATEGY:

- In 2002, provide cervical cancer education, through multi-media campaigns, one-on-one outreach, and group teachings, to at least 15,000 District women.
- Provide free Pap tests and pelvic exams to at least 1,700 uninsured or underinsured District women in over 40 provider sites.
- Priority populations to be reached include African-Americans, Hispanics, Asian/Pacific Islanders, lesbians, and women with disabilities.

- > Utilize mass mailings twice per year to distribute educational information.
- > Collaborate with local media to provide PSAs once per year.
- Utilize metro rail and bus advertisement space to raise awareness about cervical cancer once per year.
- Utilize Peer Volunteer Program monthly to provide one-on-one outreach.
- Conduct group education sessions monthly.
- Collaborate with Project WISH network providers to ensure free screenings at over 40 contracted, local sites.

RESOURCE REQUIREMENTS:

CDC and District funding for health education, screening, and follow-up.

DECEMBER 2002 TARGET: By December 2002, (1) at least 15,000 District of Columbia women will have received cervical cancer education, and (2) 1,700 uninsured or underinsured District women will receive free cervical cancer detection services.

Prostate Cancer

- 1) **2010 Goal 12-4:** The prostate cancer mortality rate has been reduced to an age-adjusted 24.4 percent per 100,000 residents, including African American men.
 - **Objective 12-4:** Reduce the prostate cancer mortality rate for African-American men to no more than 24.4 per 100,000 residents.
 - **Baseline 12-4:** The overall prostate cancer mortality rate was 27.8 per 100,000 in 1997. In African American men the rate was 32.9 per 100,000.

RECOMMENDED ACTION:

- Increase the level of awareness and knowledge of the disease among African American men, as well as
- Their access to detection, diagnostic, and treatment services, especially those men without health insurance.

RATIONALE:

Mortality rates are more likely to decline, if prostate screening rates for African American men significantly increase, in response to:

- Increased understanding of their high risk status and the importance of seeking early detection,
- · And the removal of financial/geographic barriers to clinical services.

STRATEGY:

- Expand the existing geographic distribution of community-based education and screening programs to Ward 6 where morbidity and mortality rates from prostate cancer are the third highest in the city.
- Increase the level of health communications to the public citywide.
- Establish partnerships with organizations or groups that have routine access to men, especially African American men.
- Integrate the program with other chronic disease risk reduction efforts.
- · Establish a faith-based education and awareness initiative.
- Institute a follow-up/case management system for all abnormal screening findings, especially for uninsured men.
- Increase the use of "Project Orion" mobile health screening van to reach men within their own communities.

RESOURCE REQUIREMENTS:

- Funding for core program staff.
- Funding to continue and expand contractual, community-education, early detection, and case management.

DECEMBER 2002 TARGET: By December 2002, the cancer mortality rate for African American residents will have been reduced from 32.9 per 100,000 in 1997 to an age-adjusted 29.0 per 100,000.

This section on the Cancer Registry will appear under a separate heading in the chapter on 2010 GOAL: DISEASE SURVEILLANCE which will be introduced in the next edition of the District of Columbia Healthy People 2010 Plan.

The District of Columbia Cancer Registry is a population-based cancer surveillance system that maintains a record of the occurrence of all malignant cancer cases among District residents.

In conformity with the national *Healthy People 2010* goal, the DC Cancer Surveillance System aims to provide data to monitor efforts to reduce the number of new cancer cases as well as the illness, disability, and death attributable to cancer.

Cancer Registry

1) **2010 GOAL 12-5.1:** (National 3.14): A statewide population-based cancer registry has been established to capture information on at least 95 percent of the expected number of reportable cases.

OBJECTIVE 12-5.1: Establish a statewide population-based cancer registry that captures information on at least 95 percent of the expected number of reportable cases.

BASELINE 12-5.1: As of January 2001, 101.7 percent of the expected number of reportable cases had been captured.

RECOMMENDED ACTION:

- In its section on Cancer, the national Healthy People 2010 editors describe cancer registries that provide accurate, complete, and timely data as a critical component of the public health infrastructure in the United States.
- The District will comply with the National Program of Cancer Registries (from CDC) requirements for a viable State Cancer Registry by: (a) developing legislation and regulations for enhanced registry operations, (b) meeting the standards of data quality, completeness and timeliness, and (c) providing training to registry personnel.

RATIONALE:

Data from the DOH Cancer Registry Surveillance System are critical for the following applications:

- As the foundation for a District-wide comprehensive strategy to reduce cancer morbidity and mortality;
- As an indispensable tool for health professionals in the research and analysis of the cancer burden imposed on residents;
- As the basis for monitoring and evaluation of the clinical (screening, diagnostic and treatment),
 epidemiological and supportive health services provided for residents diagnosed with cancer.

STRATEGY:

In order to ensure that at least 95 percent of the cases occurring in 2000 by the District of Columbia Cancer Registry Surveillance System are captured, the following strategies are needed:

- Contact all primary, secondary and out-of-state sources to access all cancers occurring during the 2000 calendar year.
- ➤ Conduct re-casefinding at all sources (primary and secondary) of cases diagnosed within the District of Columbia in 2000.
- > Conduct comprehensive quality control protocols (including chart audits, death certificate follow-backs and training) to ensure data gathered in 2000 are of the highest quality.
- > Continue to enforce cancer reporting regulations to ensure confidentiality of cancer data, and the timely reporting of cancer information from District facilities.
- > Submit data on cases diagnosed in 2000 for registry certification to CDC and the North American Association of Central Cancer Registries (NAACCR).

RESOURCE REQUIREMENTS:

The following resources are required for the implementation of the cancer surveillance systems:

- Local staff of one program manager, one computer programmer specialist, and four coding clerks
- Contractual staff for the District of Columbia Cancer Registry Database Management
- Computer (software and hardware) resources
- · Local and CDC funding

DECEMBER 2002 TARGET: By December 2002, capture information on at least 95 percent of the expected number of reportable cases among District residents occurring during the 1991 calendar year.

- 2) **2010 Goal 12-5.2:** Trends in the incidence of and death from lung cancer among residents are monitored by the DC Cancer Surveillance System using the District's Cancer Registry.
 - **OBJECTIVE 12-5.2:** By December, 2002, enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of cases of overall cancers among residents using the District's Cancer Registry System.
 - **12-5.2a:** Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of lung cancer among residents using the DC Registry.
 - **12-5.2b:** Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of breast cancer among residents using the DC Cancer Registry.
 - **12-5.2c:** Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of cervical cancer among residents using the DC Registry.
 - **12-5.2d:** Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of colorectal cancer among residents using the DC Cancer Registry.
 - **12-5.2e:** Enable the DC Cancer Surveillance System to monitor trends in incidence and death rates of prostate cancer in residents using the DC Cancer Registry.

BASELINE:

- **12-5.2a:** Incidence and death rates in lung cancer among residents captured by the Cancer Registry in 1997 were 62.4 and 46.7 per 100,000 population, respectively.
- **12-5.2b:** Incidence and death rates in breast cancer cases among residents captured in 1997 were 139.6 and 29.1 per 100,000, respectively.
- **12-5.2c:** Incidence and death rates in cervical cancer cases among residents captured in 1998 were 22.2 and 2.2 per 100,000, respectively.
- **12-5.2d:** Incidence and death rates in colorectal cancer cases among residents captured in 1998 were 57.1 and 17.7 per 100,000, respectively.
- **12-5.2e:** Incidence and death rates in prostate cancer cases among residents captured in 1998 were 202.0 and 27.8 per 100,000, respectively.

RECOMMENDED ACTION:

- In the section on Cancer, the national *Healthy People 2010* editors describe cancer registries that provide accurate, complete, and timely data as a critical component of the public health infrastructure in the United States.
- The District will comply with the National Program of Cancer Registries (from CDC) requirements for a viable State Cancer Registry by: (a) developing legislation and regulations for enhanced registry operations, (b) meeting the standards of data quality, completeness and timeliness, and (c) providing training to registry personnel.

RATIONALE:

Monitoring trends in total cancers, and the seven leading cancer sites is required for cancer surveillance, for the following reasons:

- The seven sites are the ones most amenable to medical intervention and most likely to have the greatest impact on cancer incidence and mortality rates.
- They account for nearly 66 percent of all incident cancers, and 55 percent of all cancer deaths in the District of Columbia.

STRATEGY:

In order to ensure that at least 95 percent of the cases occurring in 2000 by the District of Columbia Cancer Registry Surveillance System are captured, the following strategies are needed:

- Contact all primary, secondary and out-of-state sources to access all cancers occurring during the 2000 calendar year.
- ➤ Conduct re-casefinding at all sources (primary and secondary) of cases diagnosed within the District of Columbia in 2000.
- Conduct comprehensive quality control protocols (including chart audits, death certificate follow-backs and training) to ensure data gathered in 2000 are of the highest quality.
- Continue to enforce cancer reporting regulations to ensure confidentiality of cancer data, and the timely reporting of cancer information from District facilities.
- > Submit data on cases diagnosed in 2000 for registry certification to CDC and the North American Association of Central Cancer Registries (NAACCR).

RESOURCE REQUIREMENTS:

The following resources are required for the implementation of the cancer surveillance systems:

- Local staff of one program manager, one computer programmer specialist, and four coding clerks
- · Contractual staff for the District of Columbia Cancer Registry Database Management
- Computer (software and hardware) resources
- · Local and CDC funding

DECEMBER 2002 TARGET: By December 2002, gather information on a minimum of 95 percent of all cancers occurring among District residents during the 2000 calendar year in order to produce the age-adjusted cancer incidence rates.

Cardiovascular Disease and Stroke

Focus Area: Cardiovascular Disease and Stroke

 2010 GOAL 15-1: Deaths from heart disease reduced to no more than 210.5 per 100,000 residents.

OBJECTIVE 15-1: Reduce deaths from heart disease to no more than 210.5 per 100,000 residents.

BASELINE 15-1: In 1997, the age-adjusted mortality rate for heart disease was 263.2 per 100,000 District of Columbia residents.

RECOMMENDED ACTION:

The Department of Health will develop a Community and Health Systems Cardiovascular Health Needs Assessment. The assessment will provide information on the resources, policies, knowledge, attitudes, and behaviors that affect cardiovascular health in the District of Columbia.

RATIONALE:

Heart Disease is the leading cause of death in the District of Columbia. Risk factors for cardiovascular disease such as high blood pressure, elevated cholesterol, and being overweight are common among District residents. Risk-reduction strategies need to be taught and monitored.

STRATEGY:

The Department of Health will develop internal and external capacity to address cardiovascular health issues in the District of Columbia.

- The process will begin by the convening of a cardiovascular health task force.
- Second, data on cardiovascular health outcomes will be collected, analyzed and used for program planning and policy development.
- Third, an assessment of government agencies, District schools, worksites, health systems and communities will be conducted.
- Fourth, a state plan for cardiovascular health will be developed.
- In future years, projects will be developed to address gaps found in the needs assessments.

RESOURCE REQUIREMENTS:

- Strong partnerships with community-based organizations, health systems, and primary care providers.
- Four fulltime staff persons and funding for promotional and educational materials.

DECEMBER 2002 TARGET: As of December, 2002, the Department of Health will create a cardiovascular health task force that is comprised of not-for-profit, government and for profit organizations.

- As of December 2002, the Department of Health will analyze cardiovascular mortality, morbidity and risk factor data that will be published in one data fact sheet.
- As of December 2002, the Department of Heath will complete a survey of government, health system and communities that will describe the policy and environmental factors effecting cardiovascular health in the District of Columbia.
- 2) **2010 GOAL 15-8:** The rate of death from stroke in the District of Columbia has been reduced to no more than 43.2 per 100,000 residents.

OBJECTIVE 15-8: Reduce the rate of death from stroke in the District of Columbia to no more than 43.2 per 100,000 residents.

BASELINE 15-8: The age-adjusted death rate due to stroke was 54.1 per 100,000 District residents in 1997.

RECOMMENDED ACTION:

The Department of Health will develop a Community and Health Systems Stroke Needs Assessment. The assessment will provide information on the resources, policies, knowledge, attitudes, and behaviors that affect people who have stroke in the District of Columbia.

RATIONALE:

Cerebrovascular disease is the third leading cause of death in the District of Columbia. Risk factors for stroke such as high blood pressure, elevated cholesterol, and being overweight are common among District residents.

STRATEGY:

The Department of Health will develop internal and external capacity to address stroke in the District of Columbia.

- The process will begin with the convening of a cardiovascular/ stroke health task force.
- Second, data on stroke and associated outcomes will be collected, analyzed and used for program planning and policy development.
- Third, an assessment of government agencies, District schools, worksites, health systems, and communities will be conducted.
- Fourth, a state plan for cardiovascular health and stroke will be developed.
- In future years, projects will be developed to address gaps found in the needs assessment.

RESOURCE REQUIREMENTS:

- Strong partnerships with community-based organizations, health systems, and primary care providers.
- Four fulltime staff persons and funding for promotional and educational materials.

DECEMBER 2002 TARGET: By December 2002, the Department of Health (DOH) will have accomplished the following tasks:

- Created a cardiovascular and stroke health task force that is comprised of not-for-profit, government and for-profit organizations.
- Analyzed data regarding mortality, morbidity and risk factor data associated with stroke that will be published in one data fact sheet.
- Completed a survey of government, health system and communities that describes the policy and environmental factors affecting people who have strokes in the District of Columbia.

Diabetes

Focus Area: Diabetes

1) **2010 Goal 13-3:** 80 percent of District residents with diabetes report having a yearly hemoglobin A1c measurement.

OBJECTIVE 13-3: Increase to 80 percent the proportion of District residents with diabetes who report having a yearly hemoglobin A1c measurement.

Baseline 13-3: 69.8 percent of diabetic residents in the District reported having a yearly hemoglobin A1c in 1997 according to the 1997 Behavioral Risk Factor Survey (BRFSS).

Recommended Action:

According the American Diabetes Association Standards of Care, A1c measurement should be performed routinely on all patients with diabetes first to document the degree of glycemic control over time and then, if needed, to recommend changes in treatment. A yearly A1c measurement is considered the minimum level of care for this procedure.

- The Diabetes Control Program (DCP) will partner with the local Peer Review Organization to increase the number of people who receive a yearly A1c measurement (and other preventive services) and are enrolled in Medicare. The partnership will include a needs assessment of the individuals who have not received an A1c within the past year.
- By December 2002 all suggested strategies will be implemented.

Rationale:

Nearly, 30 percent of District residents did not have a yearly A1c measurement in 1997. This represents a substantial proportion of the population that did not receive a basic and necessary procedure.

Strategy:

- The DCP will hold two focus groups with Medicare beneficiaries to determine what barriers and possible solutions exist for increasing A1c measurements and other preventive services.
- The DCP will hold two focus groups with primary care providers of the Medicare enrollees to determine what barriers and possible solutions exist for increasing A1c measurements and other preventive services.

- The DCP and DELMARVA will develop an action plan based on findings from the interviews and focus groups. The action plan will address changeable barriers that are uncovered through the needs assessment.
- The DCP will adopt materials from the National Diabetes Education Program and modify them to the needs of the population. The materials will be distributed to all diabetic enrollees.
- The DCP will develop or modify an existing diabetes self-tracking pamphlet. The pamphlet allows
 the person with diabetes to track and monitor the procedures that they have received. The
 pamphlet will also be used to stimulate communication between the health care provider and
 patient. The pamphlet will be given to all participating primary health care providers and their
 beneficiaries.
- This will be assessed using Medicare claims data, HEDIS measurements, and the Behavioral Risk Factor Surveillance System.

Resource Requirements:

- Strong partnerships with community based organizations, health systems, and primary care providers.
- Two full time staff people and funding for promotional and educational materials.

DECEMBER 2002 TARGET:

- As of December 2002, two focus groups will be conducted with people having diabetes who are enrolled in Medicare and two focus groups with primary care providers who serve Medicare patients.
- By December 2002, the diabetes tracking pamphlet and Diabetes Education materials will be produced for mass distribution.
- By December 2002, all campaign materials will be distributed to their corresponding target population.
- By December 2002, baseline data will be collected from HEDIS, hospital discharge data, and the BRFSS.
- 2) **2010 Goal 13-5**: 85 percent of District residents with diabetes report having had a dilated eye exam in the past year.
 - **Objective 13-5:** Increase to 85 percent the percentage of District residents with diabetes who report having a dilated eye exam within the past year.
 - **Baseline 13-5:** 78.1 percent of District residents reported having a dilated eye exam in 1997 (BRFSS).

Recommended Action:

Comprehensive dilated eye and visual examinations should be performed annually by an ophthalmologist or optometrist who is knowledgeable and experienced in the management of diabetic retinopathy for:

- All patients age 10 years and older who have had diabetes for 3–5 years,
- All patients diagnosed after age 30, and
- Any patient with visual symptoms and/or abnormalities.

The DCP will partner with the local Peer Review Organization to increase the number of people who receive a dilated eye exam (and other preventive services) and are enrolled in Medicare. The partnership will include a needs assessment of the individuals who have not received a dilated eye exam within the past two years. By December 2002, all suggested strategies will be implemented.

Rationale:

- In 1997 there were 38 new cases of blindness due to diabetes.
- Diabetes related eye disease is preventable.
- Complications from diabetic eye disease can be minimized, if the appropriate treatment is initiated early on in the disease process.

Strategy:

- The DCP will hold two focus groups with Medicare beneficiaries to determine what barriers and possible solutions exist for increasing dilated eye exams and other preventive services.
- The DCP will hold two focus groups with primary care providers of the Medicare enrollees to determine what barriers and possible solutions exist for increasing dilated eye exams and other preventive services.
- The DCP and DELMARVA will develop an action plan based on findings from the interviews and focus groups. The action plan will address changeable barriers that are uncovered through the needs assessment.
- The DCP will adopt materials from the National Diabetes Eye Education Project and modify them to the needs of the population. The materials will be distributed to all diabetic enrollees.
- The DCP will develop or modify an existing diabetes self-tracking pamphlet. The pamphlet allows
 the person with diabetes to track and monitor what procedures they have received. The pamphlet
 will also be used to stimulate communication between the health care provider and the patient.
 The pamphlet will be given to all participating primary health care providers and their
 beneficiaries.
- Educational and promotional campaigns using the radio, television, and print media will be initiated to encourage people with diabetes to receive a dilated eye exam. Community partners will also be asked to aid in developing and disseminating campaign messages. This step will be measured by assessing the number of people who report having a dilated eye exam in the past year.

Resource Requirements:

- Strong partnerships with community based organizations, health systems, and primary care providers.
- Two full time staff people and funding for promotional and educational materials.

DECEMBER 2002 TARGET: As of December 2002, the following will have been accomplished:

- The Diabetes tracking pamphlet and Diabetes Education materials will be produced for mass distribution.
- All campaign materials will be distributed to their corresponding target population.
- Baseline data will be collected from HEDIS, hospital discharge data, and the BRFSS.
- Commercials encouraging people with diabetes to receive various diabetes health exams will be aired to target populations.
- 3) **2010 Goal 13-6:** 75 percent of District residents report having their feet checked for sores or irritations by a health care professional within the past year.
 - **Objective13-6:** Increase to 75 percent the proportion of District residents with diabetes having their feet checked for sores or irritations by a health care professional in the past year.
 - **Baseline 13-6:** In 1997, 57 percent of District residents with diabetes reported having a foot exam by a health care professional with in the past year.

Recommended Action:

- The American Diabetes Association Standards of Care states that all individuals with diabetes should receive an annual foot examination to identify high-risk foot conditions. This examination should include assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity.
- Early recognition and management of independent risk factors for ulcers and amputations to prevent or delay the onset of adverse outcomes.
- The DCP will partner with the local Peer Review Organization to increase the number of people
 who receive a foot exam (and other preventive services) and are enrolled in Medicare. The
 partnership will include a needs assessment of the individuals who have diabetes and their health
 care providers.
- By December 2001, all suggested strategies will be implemented.

Rationale:

- In 1997, 43 percent of all District residents with diabetes did not have a foot exam by a health professional in the past year.
- Additionally, there were 177 lower extremity amputations performed due to diabetes.

Strategy:

- Primary care providers will be targeted as change agents to increase the number of foot examinations performed on patients with diabetes.
- Educational and promotional campaigns will be initiated to encourage people with diabetes to
 examine their own feet and to request that their feet be checked whenever they visit a health care
 provider.
 - The DCP will hold two focus groups with Medicare beneficiaries to determine what barriers and possible solutions exist for increasing foot examinations and other preventive services.
 - The DCP will hold two focus groups with primary care providers of the Medicare enrollees to determine what barriers and possible solutions exist for increasing foot examinations and other preventive services.
 - The DCP and DELMARVA will develop an action plan based on findings from the interviews and focus groups. The action plan will address changeable barriers that are uncovered through the needs assessment.
 - The DCP will adopt materials from the National Diabetes Education Program (NDEP) and modify them to the needs of the population. Materials may also be created to support NDEP materials. The materials will be distributed to all diabetic enrollees.
 - The DCP will develop or modify an existing diabetes self-tracking pamphlet. The pamphlet allows the person with diabetes to track and monitor procedures that they have received. The pamphlet will also be used to stimulate communication between the health care provider and the patient. The pamphlet will be given to all participating, primary health care providers and their staff.
 - Educational and promotional campaigns using the radio, television, and print media will be initiated to encourage people with diabetes to ask their doctors about checking their feet during a doctor's visit. Community partners will also be asked to aid in developing and disseminating campaign messages. This step will be measured by assessing the number of people who report having a foot exam in the past year.

Diabetes

Resource Requirements:

- Strong partnerships with community based organizations, health systems, and primary care providers
- Two full time staff people and funding for promotional and educational materials

DECEMBER 2002 TARGET: As of December 2002, the following will have been accomplished:

- The diabetes tracking pamphlet and Diabetes Education materials will be produced for mass distribution.
- All campaign materials will be distributed to their corresponding target population.
- Baseline data will be collected from HEDIS, hospital discharge data, and the BRFSS.
- Commercials encouraging people with diabetes to receive various diabetes health exams will be aired to target populations.

Disabilities

Focus Area: Disabilities

1) **2010 Goal 14-1:** 100 percent of the District of Columbia Department of Health data collection instruments designed to capture demographic data on District residents include a standardized set of questions that identify people with disabilities.

Objective 14-1: Include in the core of all relevant District of Columbia Department of Health (DOH) Data collection instruments designed to capture demographic data on District residents a standardized set of questions that identify people with disabilities.

Baseline 14-1: Three of sixty programs within the Dept. of Health currently collect information that identifies people with disabilities (as of 8/2001).

Recommended Actions:

- Evaluate data sources through the examination of: (1) the instruments that DOH programs utilize to collect health related information from District residents, (2) surveys and annual reports, and (3) reports pertaining to the health needs of District residents.
- Provide training and technical assistance to representatives of DOH programs that conduct surveillance activities to enhance their awareness of the need for detailed and current health statistics relative to persons with disabilities.

RATIONALE:

- The paucity of data relative to persons with disabilities "continues to thwart policy analysis and promote an "out of sight, out of mind" viewpoint (National Council on Disability, 1996).
- The Americans with Disabilities Act (ADA) is America's legislative attempt to level the playing field to ensure that people with disabilities have equal access to all services and opportunities afforded their non-disabled counterparts in the public and private sector.
- The challenge for the District of Columbia is to create an environment where this can be actualized.
- Presently, lack of detailed and current data about people with disabilities remains an obstacle to effective policy development and analysis both locally and nationally.
- National and local surveys do not routinely collect or report data on people with disabilities the
 way they collect and report data on other protected groups, i.e., women, the elderly, and people
 from diverse racial/ ethnic backgrounds.
- Disability and/ or morbidity statistics lag well behind many other areas of health statistics according to the National Council on Disability.

 Therefore, it is vital that all DOH programs that conduct citywide surveys or administer surveillance instruments for data collection purposes include a core set of parameters for collecting information on people with disabilities.

Strategy:

- Identify all of the programs in the Department of Health that conduct surveillance activities and ask that they or a designee attend a meeting to discuss the inclusion of persons with disabilities in their data collection activities. (January, 2002)
- Develop and conduct a current status survey that is designed to examine the extent to which
 persons with disabilities are included in surveillance activities conducted by the DOH programs.
 (January February, 2002)
- Convene a meeting with all identified DOH program representatives to discuss the inclusion of a core set of questions relative to persons with disabilities in relevant surveillance activities. (February)
- Collect all of the data collection instruments from DOH programs and identify all of the programs that conduct surveillance activities that do not include information about persons with disabilities in their instruments. (February April)
- Draft a letter of request that disability related questions be included in relevant and pertinent survey instrumentation, and that a person be identified who is responsible for the collection of data to serve as a representative for the program to attend a meeting where the feasibility of including this will be discussed. Include a set of recommended questions with the letter. (May)
- Convene a meeting with all program representatives to discuss the questions to be included in the instruments, and gain commitment that the questions will be incorporated in the existing instruments. (June)
- Collect and review reports that refer to data obtained from DOH surveys and/or surveillance instruments, (i.e., survey reports, annual reports) to determine the extent to which information on people with disabilities is included in data collection instruments.) (February May)
- Conduct Disability Awareness Training for the DOH community outlining the importance of collecting data identifying persons with disabilities. (June December)

Resource Requirements:

- To ensure the full implementation of Objective 14.1, it will be necessary to augment our current staff with additional personnel, i.e., database manager, system analyst, and the support of DOH IT personnel.
- In addition, an upgraded computer and relevant software are required to accommodate the data system that will be designed to store the disability data.

DECEMBER 2002 TARGET: As of December, 2002, 20 percent of DOH data collection instruments will include questions pertaining to persons with disabilities.

HIV/AIDS

Focus Area: HIV/AIDS

1) **2010 GOAL 16-5:** By 2010, approximately 31,000 residents will have received HIV antibody testing and counseling services. *(y-t-d figure)*.

OBJECTIVE 16-5: Increase by 48 percent the number of residents receiving HIV antibody testing and counseling, with focus on injection drug users, and persons in jails and prisons.

BASELINE 16-5: 21,000 residents received HIV antibody testing and counseling services as of July, 2001.

Responsible Sexual Behavior is a Leading Health Indicator.

RECOMMENDED ACTION:

To reduce the incidence of HIV/AIDS, the HIV/AIDS Administration (HAA) will heighten awareness of HIV risks and infection, forge partnerships with other agencies and community-based organizations, and provide learning opportunities related to reduction of risks and infection through a comprehensive and aggressive HIV prevention effort in the community.

RATIONALE:

The timely access to HIV antibody testing and counseling, especially in highly affected communities, will increase awareness and knowledge of preventive and protective behaviors that reduce the risk of exposure to infection.

STRATEGY:

- Expand the availability of testing and counseling facilities to Wards 4,5,6, and 8 of the District through partnerships with providers who are rooted in the community as is SHILOH Baptist Church (a faith-based organization), ORION, Us Helping Us and other community-based organizations.
- Intensify testing and counseling in communities experiencing the highest rate of new HIV infection through partnerships with other DOH agencies and community organizations such as APRA, Maternal and Child Health, TB/Chest clinics, STD clinics, and others.
- Expand the network of organizations that are willing to work with HAA to provide counseling and testing in non-traditional venues.

RESOURCE REQUIREMENTS:

A total of four full-time employees will be needed to expand the availability of testing and counseling services in targeted wards in the District.

DECEMBER 2002 TARGET: As of December 2002, about 25, 200 residents would have received HIV antibody testing and counseling services, with a special focus on injection drug users and persons in jails and prisons.

2) **2010 GOAL 16-7:** Approximately 500 housing slots are available for residents with HIV/AIDS.

OBJECTIVE 16-7: By the end of 2002, increase by 31 percent the number of housing slots designated for persons with HIV/AIDS.

BASELINE 16-7: 380 housing slots were available to residents with HIV/AIDS in 2000.

RECOMMENDED ACTION:

Due to the disproportionate impact of HIV in the District of Columbia, HAA continuously administers a comprehensive and aggressive housing program.

RATIONALE:

The significant numbers of persons with HIV/AIDS who are homeless or at risk of homelessness in the District of Columbia pose a threat to continuous provision of care and improvement of quality of life.

STRATEGY:

- Conduct an inventory of HAA funded and non-HAA funded housing slots to identify new and available housing for residents with HIV disease.
- Identify new housing providers who may be interested in providing housing to DC residents with HIV/AIDS.
- Implement the Gatekeepers Program that will integrate and improve access to housing and other supportive services for residents with HIV/AIDS.

RESOURCE REQUIREMENTS:

Five fulltime equivalents (FTE) to coordinate and implement all Housing Program Initiatives will be needed.

DECEMBER 2002 TARGET: By December 2002, 418 housing slots will be available for residents with HIV/AIDS.

3) **2010 GOAL 16-3.1:** The number of adult and adolescent residents who have HIV disease receiving early medical intervention and secondary prevention efforts that comply with Public Health Service guidelines will be increased.

OBJECTIVE 16-3.1: Increase the number of adult and adolescent residents who have HIV disease receiving early medical intervention and secondary prevention efforts that comply with Public Health Service guidelines.

BASELINE: In 2001, 850 clients accessed medication through the AIDS Drug Assistance Program (ADAP) and 6180 clients accessed primary medical-related services.

RECOMMENDED ACTION:

Increase and intensify programs that will provide access to lifesaving medications and primary medical and related services to District residents afflicted with HIV.

RATIONALE:

The advent of new treatment modalities and improved medical management of HIV have improved the quality of health outcomes and increased the life expectancy of persons with HIV/AIDS.

STRATEGY:

- Encourage more primary care physicians to refer clients to ADAP through the use of focused awareness-raising regarding ADAP services in media campaigns, outreach and other strategies.
- Increase client's adherence to taking medications in a timely and accurate manner through the Medi-mom Program, a pilot program using pagers to remind clients about taking medications. Also the Medi-mom Program will provide intensive information dissemination using the pagers.
- Improve and increase access to primary care providers through access advocacy and outreach to communities most impacted with HIV/AIDS.

RESOURCE REQUIREMENTS:

- A total of 13 FTEs will be needed to expand primary medical care and related services in the District of Columbia.
- A total of 6 FTEs will be needed to implement ADAP's strategies to increase clients accessing lifesaving HIV medications.

DECEMBER 2002 TARGET: By December 2002, the number of residents receiving lifesaving medications through ADAP has been increased by 3.5 percent from 850 in 2001 to 880 and the number of those with HIV accessing primary medical care and related services has been increased by 5 percent from 6180 in 2001 to 6489.

Immunization

Focus Area: Immunization

1) **2010 GOAL 17-3:** Immunization coverage has been maintained at 95 percent for children in licensed child care facilities and Head Start Centers.

Objective 17-3: Maintain immunization coverage at 95 percent for children in licensed child care facilities and Head Start Centers.

Baseline 17-3: Coverage levels in 1999 were 4 DTaP 93 percent, 3 + Polio 95 percent, 1 + MMR 97 percent, 3+ Hib 91 percent, and 1 Varicella 81 percent according to school survey data.

Immunization is a leading health indicator.

RECOMMENDED ACTION:

- To gather data on immunization coverage levels among preschoolers in the District, conduct an annual comprehensive assessment of licensed child care facilities and Head Start Centers for the 2001/2002 school year.
- For preschool children not in compliance with school law (immunization of school students -1979), develop specific recommendations and conduct special immunization clinics when appropriate.
- For improved compliance to the compulsory School Immunization Law and to conduct effective activities in areas of greatest need, conduct preschool surveys which are mandatory within this sub-population group.
- To determine immunization levels and trends, enter preschool survey data into the Central Immunization Registry System.

- Uniformly high vaccine coverage levels are required to prevent circulation of the viruses and bacteria that cause vaccine preventable diseases.
- Surveys provide data on coverage levels among the targeted groups in the District.
- Entry requirements for licensed child care facilities and Head Start Centers are some of the most effective interventions there are to ensure preschool children are appropriately immunized and therefore protected against vaccine preventable diseases.

- Immunization program personnel will conduct annual, comprehensive surveys of licensed child care facilities and Head Start Centers.
- The survey data will be entered into and analyzed by the Central Immunization Registry to determine compliance levels and what additional follow-up is needed.

RESOURCE REQUIREMENTS:

Commitment and time from immunization program personnel assessment team and the data management program, along with the support of preschool directors and school nurses.

DECEMBER 2002 TARGET: As of December, 2002, 95 percent of children attending licensed child care facilities and Head Start Centers will have completed specific coverage rates for selected antigens.

2) **2010 Goal 17-7:** 100 percent of each new birth cohort is enrolled in the Central Immunization Registry.

OBJECTIVE 17-7: Increase to 100 percent (minus any deaths) of each new birth cohort enrolled in the Central Immunization Registry.

BASELINE 17-7: This project began in the year 2001. Baseline data should be available by the end of 2001 concerning the number of cohorts enrolled by that time.

RECOMMENDED ACTION:

- The State Center for Health Statistics Administration (SCHSA) will transmit a data file including agreed upon fields for all new births to District residents to the DC Immunization Program's Central Immunization Registry System on a monthly basis.
- The Immunization Registry will add the new births' information from the file.
- Measurement of the percentage of new birth cohorts will be based on the number of new births in the Immunization Registry, compared with the number of new births reported by the SCHSA for the last available reporting year.

RATIONALE:

• The national *Healthy People 2010* objective 14-26 is to "increase the proportion of children who participate in fully operational population-based immunization registries."

- One of the key components of a fully operational population-based immunization registry according to Healthy People 2010 and the Centers for Disease Control and Prevention's National Immunization Program is that it enrolls "all children at the state or community level automatically at birth." Consequently, the immunization status of all children will be accessible to state officials and administrators.
- The most cost-effective, non-duplicative and complete means of enrolling children at birth is to use birth certificate information already collected for Vital Records.

- Representatives of the SCHSA will transmit data on a monthly basis in the agreed upon format to the DC Immunization Program's Registry.
- The applicable information then will be added to the Registry system, thereby enrolling the birth cohort in the Immunization Registry.

RESOURCE REQUIREMENTS:

Commitment and time from SCHSA staff members and its data management team and from the DC Immunization Registry team to use already established information systems and equipment to collect, transmit, and analyze birth data.

DECEMBER 2002 TARGET: As of December 2002, 75 percent of the year 2001 birth cohort will be enrolled in the Central Immunization Registry.

3) **2010 GOAL 17-9:** Increase the proportion of adults who are vaccinated annually against influenza and have ever been vaccinated against pneumococcal disease.

OBJECTIVE 17-9: Increase to 90 percent the number of non-institutionalized adults aged 65 years and older immunized against influenza; and increase to 60 percent the number of noninstitutionalized adults ages 65 years and older immunized against pneumococcal disease.

BASELINE 17-9: BRFSS* coverage level data for 1999 indicated that 54 percent of noninstitutionalized adults 65 and older were immunized with influenza vaccine and 32 percent of non-institutionalized adults 65 and older were immunized with pneumococcal vaccine. (Source: * Delmarva Foundation - Preventive health services delivered to Medicare Patients in the District of Columbia).

RECOMMENDED ACTION:

- Identify, through hospital discharge records, high-risk people and those 65 and older who need influenza and/or pneumococal vaccine.
- Motivate non-institutionalized high risk adults and those 65 and older through appropriate verbal, visual, or printed messages to consider having influenza and/or pneumococcal vaccine.
- Improve the availability of outreach community clinics for influenza and pneumococcal vaccine coverage for high-risk patients and those 65 and older who are underinsured or without Medicare coverage.
- Improve performance of physicians and other healthcare providers in avoiding missed opportunities to immunize high-risk adults and those 65 years and older with influenza and pneumococcal vaccine during contacts with health care providers in offices, outpatient clinics, and hospitals.

RATIONALE:

- One of the national Healthy People 2010 objectives, 14-29, is to increase annual influenza rates and improve the use of pneumococcal vaccine in non-institutionalized adults ages 65 and older.
- "Vaccination is an effective strategy to reduce illness and deaths due to pneumococcal disease and influenza."
- With the adult population living longer, increasing numbers of adults will be at risk for these major causes of illness and death.
- According to the national Healthy People 2010 and the Centers for Disease Control and Prevention, "continued education of providers and the community is needed to increase awareness of and demand for adult vaccination services."

STRATEGY:

- To promote collaboration and cooperation among Public Health agencies, community
 organizations and private providers in vaccinating high-risk individuals and those 65 and older as
 an efficient and effective use of resources.
- Utilize the Central Immunization Registry for a computer generated reminder system to private and public providers for high-risk patients and those over 65 years of age.
- Improve education and outreach to older adults, especially those 65 and older and adults with
 underlying health conditions, by addressing concerns about the lack of information, as well as the
 myths and misunderstandings concerning influenza and pneumococcal vaccines and fear based
 on past reactions.

RESOURCES REQUIRED:

Commitment and time from the Immunization Program, Delmarva Foundation, and the City Office of Aging, to work together and improve direct services, education and the exchange of ideas on improving influenza and pneumococcal vaccine levels in adults 65 and older and all adults with an underlying health condition.

DECEMBER 2002 TARGET: As of December 2002, 59 percent of high-risk adults or those 65 years and older will be vaccinated annually with influenza vaccine and 34 percent, if needed, pneumococcal vaccine.

Mental Health

Focus Area: Mental Health

Mental Health Services for District Children, Adolescents and Their Families

 2010 GOAL 18-1: A community support system for children or youth with mental health problems and their families is being developed through collaboration in the administration, financing, resource allocation, training and delivery of services across all appropriate public systems.

OBJECTIVE 18-1.5: Expand by 10 percent annually or the equivalent of one school cluster, the proportion of District of Columbia Public Schools and Charter Schools in which Department of Mental Health (DMH) prevention, early intervention and treatment services are available to children and their families.

BASELINE 18-1.5: As of September 2001, a full complement of prevention, early intervention, and treatment services were available in 17 Charter Schools out of a total of (147 Public Schools and) 35 Charter Schools serving District residents. A variety of other clinical services were offered in 20 additional DC Public Schools in the 2000 - 2001 academic year.

Mental health is a leading health indicator.

RECOMMENDED ACTION:

• Develop a community support system for District children and youth with mental health problems and their families through collaboration in the administration, financing, resource allocation, training and delivery of services across all appropriate public systems.

- Each child's or youth's mental health services and mental health supports are based on a single child- and youth-centered and family-focused Individual Plan of Care, encompassing all necessary and appropriate services and supports which may be delivered by both public and private entities.
- Prevention, early intervention, and mental health services and mental health supports to meet individual and special needs (1) are delivered in natural, nurturing and integrated environments,
 (2) recognize the importance of and support for the maintenance of enduring family relationships, and (3) are planned and developed within the District and as close to the child's or

- youth's home as possible, so that families need not relinquish custody to secure treatment for their children and youth.
- During the day, District children and youth of school-age are generally accessible in the school setting. Consequently, mental health (MH) services should be accessible in schools where coordinated efforts to create a nurturing and supportive environment are ongoing and where interventions are more likely to be effective.

- A needs assessment and resource mapping will occur for each of the targeted schools.
- Mental health staff will be hired and trained to provide school-based services.
- A standardized mental health referral and triage system will be approved and utilized in the schools.
- A program to include prevention, early intervention, and treatment services will be operational in six (6) schools.

RESOURCE REQUIREMENTS:

- 10.5 FTEs to begin program implementation for clinical staff and administrative staffing needs
- Pagers/beepers and computers for all clinical staff
- Psychological testing equipment and materials/supplies to supplement clinical work

DECEMBER 2002 TARGET: By December 2002, approximately 8 percent (n=23) of DC Public Schools and Charter Schools will have a full complement of mental health prevention, early intervention, and treatment services available to children and their families.

Mental Health Services for Adult Residents of the District of Columbia

2) **2010 GOAL 18-2:** A system of care is being established for adult residents who are mentally ill in the District of Columbia.

OBJECTIVE 18-2: Establish a comprehensive system of care for adult residents of the District of Columbia who are mentally ill which is based on an Individual Recovery Plan.

BASELINE 18-2: An inventory of available mental health services is underway. Data will be added when available.

RECOMMENDED ACTION:

- Develop a community support system for persons with mental illness through collaboration in the administration, financing, resource allocation, training and delivery of services across all appropriate systems.
- The mental health services and mental health supports provided to each consumer will be based on an Individual Recovery Plan designed to promote recovery and develop social, community and personal living skills, and to meet essential human needs.
- This Plan includes the appropriate integrated, community-based outpatient services and inpatient
 care, outreach, emergency services, crisis intervention and stabilization, age-appropriate
 educational and vocational readiness and support, housing and residential treatment and support
 services, family and caregiver supports and education and services to meet special needs which
 may be developed by both public and private entities.

RATIONALE:

- In order to effectively address the mental health needs of the District's consumers, a
 comprehensive view of issues and factors impinging upon the adaptive abilities of the consumer
 must be considered.
- In order to accomplish this, best practice studies indicate that interagency and community partnerships are required.
- Through such collaborations, administrative, fiscal and resource allocation efforts can be
 effectively maximized and linked for the purpose of ensuring integration and continuity of service
 delivery in meeting the mental health needs of the District's consumers.
- Through the development of the Individual Recovery Plan (IRP) for Adults, a plan for services is fashioned and administered to meet the individual and unique needs and preferences of each consumer, in order to promote the highest possible level of adaptive functioning within the community.
- Through the administration of community-based, mental health support services, DMH's goal is
 to minimize the need for inpatient, psychiatric care among the District's consumers whenever
 possible.

STRATEGY:

- Access and care coordination processes will be developed to ensure that those in need of and seeking mental health services have unencumbered access to such services at levels of care that are commensurate with their need.
- Interagency collaborations and partnerships that serve the best interest of the District's mental health consumer population will be established for the purpose of ensuring effective coordination of service development and delivery.

 A full array of integrated, community-based services that are designed to support the highest levels of adaptive functioning will be provided by public and private agencies to those in need of and seeking such services.

RESOURCE REQUIREMENTS:

- Approximately 17 FTEs are needed for full program implementation and operation of the access and care coordination processes.
- Development of an approved IRP document.
- Implementation of the Contract Management System.

DECEMBER 2002 TARGET: By December 2002, access and care coordination processes will be fully operational, in order to ensure service access for 100 percent of those adult consumers entering the mental health system through the access, referral and crisis line.

Mental Health Services to Homeless People with Serious Mental Illness Who are 18 Years of Age and Older

3) 2010 GOAL 18-2.2: Expanded services to homeless people 18 years and older who have serious mental illness are available through teams of DMH outreach workers.

OBJECTIVE 18-2.2 c: Bring MH services to homeless persons in the District of Columbia through approximately 200 contacts per month by a team of three homeless outreach workers.

BASELINE 18-2.2c: The DMH Homeless Outreach Program currently makes over 100 contacts per month with homeless individuals residing in shelters or on the street. Other services provided by DMH programs (Homeless Support Teams and drop-in center) total approximately 2,800 contacts per month).

RECOMMENDED ACTION:

In January 2001, the Washington Council of Governments in conjunction with the Community Partnership for the Prevention of Homelessness and other service providers for homeless individuals and families conducted a regional survey of the homeless population. There were about 7,100 homeless persons counted in the District of Columbia who were living in shelters and on the street. Approximately one third of these persons are presumed to have a mental illness or have a dual diagnosis of mental illness and substance addiction.

- The DMH has targeted services to persons who are homeless including:
 - ➤ Two homeless support teams serving a total of 250 consumers.
 - ➤ A drop-in center serving up to 80 consumers per day.
 - > Three homeless outreach workers who make over 100 contacts with homeless persons per month
 - > Six fourth year psychiatric residents providing assessments, treatment and counseling at shelters in the District of Columbia.
- The Homeless Services Program will acquire a psychiatrist to work with the outreach team to provide additional leadership in assessing homeless individuals with complex problems including mental illness, addiction and chronic health issues.
- The Homeless Services Psychiatrist will also assist the team in providing training to private sector outreach workers to improve their skills in addressing the problems of homeless individuals. The psychiatrist will oversee clinical case conferences that review cases of chronically ill homeless persons to determine appropriate interventions. These interventions often involve multiple kinds of health care (psychiatric, medical, and addiction).

RATIONALE:

While it is believed that at least 30 percent of the homeless population has a mental illness, DMH recognizes that many individuals who are homeless experience undiagnosed illness and addictions. Due to the transcience of homelessness, it is often difficult to find and assess these individuals in the areas they frequent. The addition of a psychiatrist to the Homeless Services Program will help to address this issue.

STRATEGY:

- Conducting a study of DMH programs that serve homeless individuals and developing a performance indicator for homeless services are preliminary steps to be taken in the fall of this year (2001) in preparation for the implementation of DMH service provider teams.
- A psychiatrist will work with the DMH Homeless Outreach Program to visit individuals in shelters
 and on the street and to improve DMH's coordination with other agencies (public and private)
 that provide outreach and services to the homeless population.
- This coordination will involve increased training to outreach and service providers and regular case consultations with agencies to ensure assessments and linkages are appropriate.

RESOURCE REQUIREMENTS:

The DMH Homeless Services Program will add a psychiatrist to its staff to improve outreach services and coordination with other homeless service providers.

DECEMBER 2002 TARGET: By December 2002, the team of outreach workers will make approximately 200 contacts per month with homeless persons in the District and provide a minimum of six (6) trainings to shelter and other homeless services staff.

Sexually Transmitted Diseases

Focus Area: Sexually Transmitted Diseases

1) **2010 GOAL 19-3:** The incidence of primary and secondary syphilis is reduced to no more than 3 cases per 100,000 people in the District.

OBJECTIVE 19-3: Reduce the incidence of primary and secondary syphilis in the District to no more than 3 cases per 100,000 people.

BASELINE 19-3: The primary and secondary syphilis rate in the general population in the District was 7.1 per 100,000 people in the year 2000.

Responsible sexual behavior is one of the leading health indicators.

RECOMMENDED ACTION:

The STD Program expects to reduce primary and secondary syphilis among District residents by:

- Expanding screening sites
- Educating more women
- Continuing safe sex presentations during counseling sessions in clinical settings
- Providing patients with male and female condoms

- "The rate of spread of communicable diseases in a population is determined by three factors: (1) the rate of exposure of susceptible persons to infected individuals, (2) the probability that an exposed, susceptible person will acquire the infection (i.e., the "efficiency of transmission"), and (3) the length of time that newly infected person remains infected and is able to spread the infection to others."
- "Interventions can prevent the spread of an STD within a population by reducing the rate of
 exposure to an STD. A sustained prevention program can drive the infection to extinction in the
 entire population, even when these interventions are provided only to individuals and social
 networks with the highest rates of transmission." (Anderson, 1991). (Source: The Hidden
 Epidemic: Confronting Sexually Transmitted Diseases, Thomas R. Eng and William T. Butler,
 editors, 1997, The Institute of Medicine, National Academy of Sciences.)

- Ensure that all STD morbidity and case-related data are entered into the case records within 24 hours of closure.
- Ensure that at least 90 percent of in-jurisdiction reactive serologies are reported within 24 hours of the date the test result is read.
- Interview 90-95 percent of early syphilis cases reported in 2002.
- Ensure that a minimum of 0.7 new sex partners are referred, examined and given preventive or therapeutic treatment for each case of syphilis interviewed.
- Ensure that at least 95 percent of epidemiological and administrative staff in the District's public STD clinic receives one or more training sessions during the year.
- By September 1, 2002, ensure that at least 95 percent of the major providers in the District are in possession of CDC guidelines for the treatment and management of STD infections.
- By December 31, 2001, ensure that the Bureau receives at least 95 percent of all positive syphilis reports within 24 hours of test result.
- Ensure that at least 95 percent of all early syphilis cases diagnosed are entered into the surveillance system without mistakes within 24 hours of interview.
- Continue conducting active syphilis surveillance by assigning liaisons to visit four critical "sentinel" providers at least twice a week to Howard University Hospital, Providence Hospital, the DC Detention Center, and Washington Hospital Center. These liaisons will provide active surveillance by reviewing laboratory reports, medical records, and Emergency Room logs at these provider sites on a weekly basis for STD test results, demographic data and symptom indications. These provider sites were selected because they are all located in high morbidity areas and each has difficulty providing information to the Bureau in an expedient manner.
- By July 1, 2002, assure that at least five community-based organizations serving at-risk populations in Wards 1,2,5,6, and 8 distribute STD/syphilis prevention literature and condoms to at least 10,000 patients. Ensure that these organizations have adequate resources to conduct syphilis screening and testing.
- Continue funding three community-based organizations providing syphilis outreach activities (including screening, condom distribution, and education) to at least 5,000 people yearly through July 1, 2002.
- Implement a District-wide media strategy to promote STD prevention messages among at-risk populations by April 1, 2002.
- Develop a plan to conduct quarterly syphilis prevalence monitoring on high-risk groups (pregnant females, adolescents, and persons in drug treatment facilities) by December 31, 2001.

RESOURCE REQUIREMENTS:

(Approximately) 2 million annually to cover costs for personnel, buildings, utilities, and laboratory support.

DECEMBER 2002 TARGET: As of December, 2002, the incidence of primary and secondary syphilis is reduced from 7.1 cases per 100,000 to 6.1 cases per 100,000.

2) **2010 GOAL 19-4:** The incidence rate for congenital syphilis has been reduced to no more than 10 cases per 100,000 live births.

OBJECTIVE 19-4: Reduce the incidence of congenital syphilis to no more than 10 cases per 100,000 live births.

BASELINE 19-4: The incidence rate for congenital syphilis in the year 2000 was 52.0 per 100,000 live births.

RECOMMENDED ACTION:

The STD Program expects to reduce primary and secondary syphilis among District residents by:

- Expanding screening sites
- Ensuring timely treatment and counseling
- Educating more women
- Continuing safe sex presentations during counseling sessions in clinical settings, and
- Providing patients with male and female condoms

RATIONALE:

- "The rate of spread of communicable diseases in a population is determined by three factors: (1) the rate of exposure of susceptible persons to infected individuals; (2) the probability that an exposed, susceptible person will acquire the infection (i.e., the "efficiency of transmission"); and (3) the length of time that newly infected person remains infected and is able to spread the infection to others."
- "...Interventions can prevent the spread of an STD within a population by reducing the rate of exposure to the STD. A sustained prevention program can drive the infection to extinction in the entire population, even when these interventions are provided only to individuals and social networks with the highest rate of transmission." (Anderson, 1991) (Source listed on p. 78).

STRATEGY:

- Ensure that all STD morbidity and case-related data are entered into the case records within 24 hours of closure.
- Ensure that at least 90 percent of in-jurisdiction reactive serologies are reported within 24 hours of the date the test result is read.

- Interview 90-95 percent of early syphilis cases reported in 2002.
- Ensure that a minimum of 0.7 new sex partners are referred, examined and given preventive or therapeutic treatment for each case of syphilis interviewed.
- Ensure that at least 95 percent of epidemiological and administrative staff in the District's public STD clinic receives one or more training sessions during the year.
- By September 1, 2002, ensure that at least 95 percent of the major providers in the District are in possession of CDC guidelines for the treatment and management of STD infections.
- By December 31, 2001, ensure that the Bureau receives at least 95 percent of all positive syphilis reports within 24 hours of test result.
- Ensure that at least 95 percent of all early syphilis cases diagnosed are entered into the surveillance system without mistakes within 24 hours of interview.
- Continue conducting active syphilis surveillance by assigning liaisons to visit four critical
 "sentinel" providers at least twice a week to Howard University Hospital, Providence Hospital, the
 DC Detention Center, and Washington Hospital Center. These liaisons will provide active
 surveillance by reviewing laboratory reports, medical records, and Emergency Room logs at
 these provider sites on a weekly basis for STD test results, demographic data and symptom
 indications. These provider sites were selected because they are all located in high morbidity
 areas and each has difficulty providing information to the Bureau in an expedient manner.
- By July 1, 2002, assure that at least five community-based organizations serving at-risk populations in Wards 1,2,5,6, and 8 distribute STD/syphilis prevention literature and condoms to at least 10,000 patients. Ensure that these organizations have adequate resources to conduct syphilis screening and testing.
- Continue funding three community-based organizations providing syphilis outreach activities (including screening, condom distribution, and education) to at least 5,000 people yearly through July 1, 2002.
- Implement a District-wide media strategy to promote STD prevention messages among at-risk populations by April 1, 2002.
- Develop a plan to conduct quarterly syphilis prevalence monitoring on high-risk groups (pregnant females, adolescents, and persons in drug treatment facilities) by December 31, 2001.

RESOURCE REQUIREMENTS:

(Approximately) 2 million annually to cover costs for personnel, buildings, utilities, and laboratory support.

DECEMBER 2002 TARGET: As of December 2002, the incidence rate for congenital syphilis has been reduced from 52.0 cases per 100,000 to no more than 42.0 cases per 100,000 residents.

3) **2010 GOAL 19.1:** The proportion of women testing positive for Chlamydia trachomatis in the District's STD Clinic has been reduced by 3.2 percent and in the family planning clinics by 4.92 percent.

OBJECTIVE 19-1: Reduce the proportion of women in the District of Columbia testing positive for Chlamydia trachomatis infections in the STD Clinic by 3.28 percent and in family planning clinics by 4.92 percent.

BASELINE 19-1: The proportion of women in the District of Columbia testing positive for Chlamydia trachomatis infections in the STD Clinic was 6.0 percent (146 of 2,428) and in family planning clinics 3.8 percent (108 of 2,801) in 2000.

RECOMMENDED ACTION:

The Chlamydia Screening Project expects to reduce positivity rates of women by:

- Expanding screening sites
- Educating more women
- Continuing safe sex presentations during counseling sessions in clinical settings
- Providing patients with male and female condoms

These recommended actions are based on the success demonstrated in the Pacific Northwest where extensive screening began in family planning clinics in 1988 and in STD clinics in 1993; prevalence declined from 10 to 4 percent in the late 1980s and from 4 to 5 percent in 1995.

- "Pelvic Inflammatory Disease (PID) is among the most serious threats to female reproductive capability. PID is caused most frequently by Chlamydia infections and gonorrhea that ascent past the cervix into the upper reproductive tract. PID often results in scarring and either complete or partial blockage of the Fallopian Tubes." (Healthy People 2010, conference edition 25-21)
- The DC Chlamydia Project proposes to meet the prevention target of 86 cases of PID for 2002 by identifying 202 women with chlamydia for treatment purposes. Treating these chlamydiainfected women through the project will result in the prevention of 86 cases of PID, with an estimated economic benefit of \$100,362.00 (\$1,167.00 per case) projected for 2002.

- Selectively screen 2,000 patients at the STD Clinic.
- Selectively screen 5,000 patients at the Family Planning Clinics.
- Assure treatment for 90 -95 percent of patients testing positive for chlamydia at all project sites.
- Provide counseling to a minimum of 90-95 percent of patients treated for chlamydia on risk reduction behaviors related to chlamydia infection, prevention, and control.
- Make appropriate referrals to other medical and social service providers for women screened (e.g., drug and alcohol programs).
- Provide partner referral counseling/interview for 60 percent of patients who are treated for chlamydia.
- Provide outreach services and education to 45,000 health care providers, health educators, and other health consumers targeting women to inform them of the availability of chlamydia testing.
- Implement ongoing training services for one clinician, one counselor, and one support staff.
- To ensure proper presumptive treatment for 80 percent of patients attending the STD Clinic testing positive for chlamydia and 25 percent of patients attending the family planning sites.

RESOURCE REQUIREMENTS:

\$150,000 annually:

- For Southeast STD Clinic screening services for chlamydia
- Of this sum approximately half is used to support the contract with Planned Parenthood of Metropolitan Washington.

DECEMBER 2002 TARGET: As of December, 2002, the proportion of women testing positive for Chlamydia trachomatis in the District's STD Clinic has been reduced by at least 0.5 percent to 5.5 percent and in the family planning clinics by at least 0.5 percent to 3.3 percent.

Substance Abuse

Focus Area: Substance Abuse

1) **2010 GOAL 20-1:** No more than 50 percent of youth report ever having tried cigarette smoking.

OBJECTIVE 20-1: Reduce to no more than 50 percent the proportion of youth who have ever tried cigarette smoking.

BASELINE 20-1: 62.9 percent of boys and girls have tried smoking, according to the 1999 District of Columbia Youth Risk Behavior Survey (YRBS).

Substance abuse is a leading health indicator.

RECOMMENDED ACTION:

- Implement plan to educate District residents on preventing the abuse of alcohol, tobacco and other drugs (ATOD).
- Provide vendor education and in-store display materials to 500 merchants to comply with regulations prohibiting tobacco sales to minors.
- Encourage and assist in the development of community coalitions and new programs on ATOD prevention.
- Provide classroom presentations to students in public and charter schools on the hazards of tobacco use.
- Sponsor and partner with other public and private entities addiction awareness events, i.e., an annual Awareness Day, community health fairs, and youth specific events.

RATIONALE:

- The number of District youth reported to have ever tried cigarette smoking increases daily.
- Nationally, each day, 3,000 new youth report smoking their first cigarette.

STRATEGY:

- Distribute 500,000 pamphlets on alcohol, tobacco and other drugs (ATOD) abuse prevention to residents.
- Distribute substance abuse prevention information throughout District neighborhoods, including District public and charter schools, in order to reach 35,000 youth.
- Conduct outreach, community presentations and health fairs, in order to reach 250,000 residents.

- Provide training on substance abuse prevention to 500 persons including staff of community-based organizations, school personnel, faith leaders, parents, and other youth workers.
- Award 10-15 grants to community-based organizations to provide prevention programs to children, youth and families; to develop and implement community-based and environmental strategies for ATOD prevention.

RESOURCE REQUIREMENTS:

- Continuation of the distribution of tobacco compliance videos, literature, and counter mats to vendors.
- Continued annual compliance checks of approximately 1,200 merchants.
- Continued partnerships with tobacco control office, private sector health associations, and District of Columbia public schools.
- Block grant funds to award grants to community-based organizations for the conducting of ATOD prevention programs.

DECEMBER 2002 TARGET: As of December 2002, 59.7 percent of boys and girls report having tried smoking (a decrease of 5 percent from 62.9 percent in 1999).

2) **2010 GOAL 20-2:** No more than 51 percent of youth report that they have ever drunk alcohol.

OBJECTIVE 20-2: Reduce to 51 percent the proportion of youth who have ever drunk alcohol.

BASELINE 20-2: Of District youth 66.5 percent reported drinking alcohol according to the 1999 District of Columbia YRBS.

RECOMMENDED ACTION:

- Provide workshops and presentations to youth enrolled in after school programs.
- Conduct Drug Abuse Resistance Education (DARE) programs at the DCPS elementary and junior high schools.
- Enhance adolescent's refusal skills for alcohol and other drugs through classroom presentations, prevention workbooks and materials.

RATIONALE:

• While the drinking rates for District of Columbia high school students are below the national average (according to the federal Centers for Disease Control), prevention of alcohol use by the city's young people remains a paramount issue.

• The District of Columbia has the third highest per capita alcohol consumption rate in the nation, according to the *1999 Facing Facts: Drugs and the Future of Washington, DC,* issued by Drug Strategies.

STRATEGY:

- Provide prevention education at 50 percent of the District's public and charter schools.
- Empower youth through education and knowledge to change their attitudes toward ATOD use.
- Enhance adolescent's refusal skills for alcohol and other drugs.
- By 2010, reduce by 5 percent the proportion of young people who have used alcohol, marijuana and cocaine in the past month.

RESOURCE REQUIREMENTS:

- Use of block grant funds to award grants to community-based organizations to conduct ATOD prevention programs.
- Acquisition and dissemination of drug prevention literature from national clearinghouses.
- · Continued partnerships with District public and charter schools.
- · Increased staff and consultant capacity.
- Increased enforcement by Alcohol and Beverage Control agents and District police of ban on sales to minors.

DECEMBER 2002 TARGET: As of December 2002, 63.5 percent of District youth will report having had one or more drinks during their lifetime (a decrease of 5 percent from 66.5 percent in 1999).

3) **2010 GOAL 20-3:** No more than 20 percent of youth report that they have ever used marijuana.

OBJECTIVE 20-3: Reduce to 20 percent the proportion of youth who have ever used marijuana.

BASELINE 20-3: Of District of Columbia youth, 45.1 percent reported use of marijuana one or more times during their lifetime, according to the 1999 DC YRBS.

RECOMMENDED ACTION:

- Educate youth and community residents about risk factors for potential drug use.
- Strengthen protective factors to produce resiliency in youth.
- Raise awareness of parents and the community about the level of youth involvement with marijuana and strategies they can use to influence youth drug-taking behavior.

RATIONALE:

- Marijuana is a gateway drug and may possibly lead to use of other illicit drugs.
- The overall use of marijuana has decreased, however, the rate of use remains high for District students in the 12th grade.
- Prevention of marijuana use may lead to the prevention of additional ATOD use.

STRATEGY:

- Provide substance abuse prevention education at 50 percent of the District's public and charter schools.
- Provide educational material to 100,000 District youth and adult residents on the harmful physical effects of marijuana use.
- Conduct 24 workshops for children and youth participants in after-school programs.

RESOURCE REQUIREMENTS:

- Utilize block grant funds to award grants to community-based organizations to conduct ATOD prevention programs.
- Acquire and disseminate drug prevention literature from national clearinghouses.

DECEMBER 2002 TARGET: As of December 2002, 42.8 percent of District youth will report having used marijuana one or more times during their lifetime (a decrease of 5 percent from 45.1 percent in 1999.).

Tuberculosis

Focus Area: Tuberculosis

1) **2010 GOAL 21-1:** The incidence of tuberculosis in the District of Columbia has been reduced to no more than 9.9 cases per 100,000 people.

OBJECTIVE 21-1: Reduce the incidence of tuberculosis (TB) in the District of Columbia to no more than 9.9 cases per 100,000 people.

For <u>Asian/Pacific Islanders</u>, from 3.3 cases per 100,000 people in 1999 to no more than 1.5 cases per 100,000 in 2010.

For <u>African Americans</u>, from 16.3 cases per 100,000 people in 1999 to 10 cases per 100,000 people in 2010.

For <u>Hispanics</u>, from 16.0 cases per 100,000 people in 1999 to 5 cases per 100,000 people in 2010.

For <u>American Indian/Alaska Natives</u>, from no cases in 1999 to 0.5 cases per 100,000 people in 2010.

BASELINE 21-1: 13.7 cases of tuberculosis per 100,000 people in 1999.

RECOMMENDED ACTION:

- Continued collaboration with hospitals, clinics, shelters, correctional facilities and other locations where TB patients and those at risk for TB receive services to (1) identify TB cases and (2) ensure timely, appropriate and complete treatment for their TB.
- Targeted screening of populations that are likely to have high rates of latent TB infection, so that preventive treatment can be offered.

- TB is transmitted from person to person.
- Early identification and treatment of infectious TB cases will prevent transmission to other persons, decreasing the number of infected persons who may develop active (infectious) TB in the future.

• Identification and treatment of persons with latent infection who are at increased risk of developing active disease will prevent future TB cases.

STRATEGY:

• Providing targeted screening of populations that are likely to have high rates of latent TB infection, so that preventive treatment can be offered.

RESOURCE REQUIREMENTS:

- Continued funding for current program personnel
- Increased program capacity to provide consultation, training, technical assistance to local health care provider

DECEMBER 2002 TARGET: By December 2002, the incidence of tuberculosis in the District of Columbia will have been reduced from 13.7 cases per 100,000 people to 12.0 cases per 100,000.

2) **2010 GOAL 21-2:** 90 percent of close contacts of persons with active tuberculosis complete the recommended preventive therapy.

OBJECTIVE 21-2: Increase to 90 percent the proportion of close contacts of persons with active tuberculosis who complete the recommended courses in preventive therapy.

BASELINE 21-2: Less than 10 percent of close contacts of persons with active tuberculosis completed preventive therapy in 1999.

RECOMMENDED ACTION:

- Increase efforts to screen, educate and treat high-risk close contacts.
- Offer directly observed preventive treatment where TB Control Program resources permit (e.g., for family members of case patients receiving Direct Observed Therapy (DOT).

- DOT has substantially improved treatment completion rates for TB cases.
- Close contacts of TB cases come from the same population and have the same risk factors for failure to complete recommended treatment.

- · Collaborate with community-based organizations to administer DOPT.
- Introduce incentives and enablers to inspire high risks contact to comply with prophylactic treatment.
- Have alternate hours of service at the Chest Clinic and send remainder messages to those who have missed treatment.

RESOURCE REQUIREMENTS:

Augmentation of existing TB Control Program data management systems to allow tracking of contacts on Direct Observed Preventive Therapy (DOPT).

DECEMBER 2002 TARGET: As of December, 50% of close contacts completed recommended preventive therapy.

NOTES

For More Information, Contact
Department of Health
State Center for Health Statistics Administration
(202) 442-9039





